

MEDICAL CONGRESS — MEDIESE KONGRES, PORT ELIZABETH

21-26 June / Junie 1954

# South African Medical Journal



# S.-A. Tydskrif vir Geneeskunde

Organ of the Medical Association of South Africa

Blad van die Mediese Vereniging van Suid-Afrika

Incorporating the South African Medical Record and the Medical Journal of South Africa

Waarby ingelyf is die South African Medical Record and the Medical Journal of South Africa

Registered at the General Post Office as a newspaper

By die posweze as nuusblad geregistreer

Cape Town, 24 April 1954  
Weekly 2s. 6d.

Vol. 28 No. 17

Kaapstad, 24 April 1954  
Weekliks 2s. 6d.

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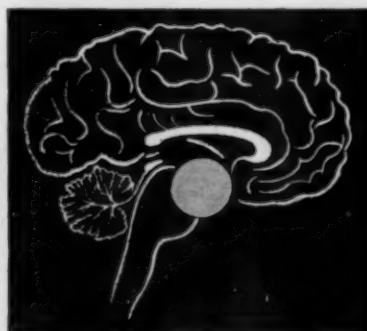
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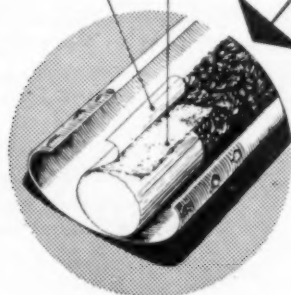
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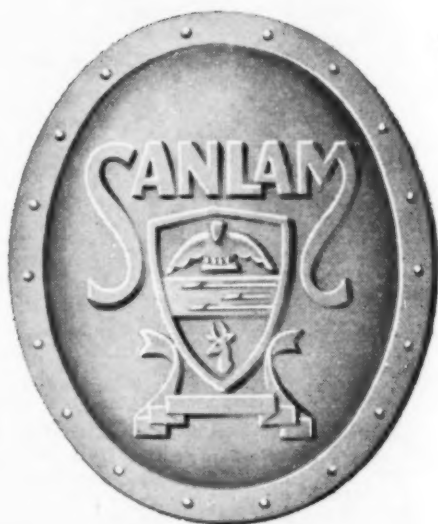
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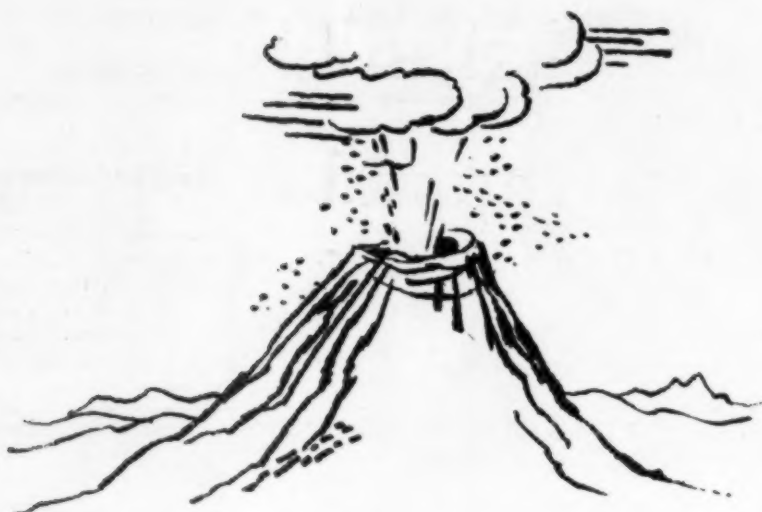
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1. Valentino, F. C. O.: *LANCET* 301 (AUG. 23) 1952.

2. Reiss, F.: *NEW YORK STATE J. MED.* 55:1081 (APR. 15) 1952.

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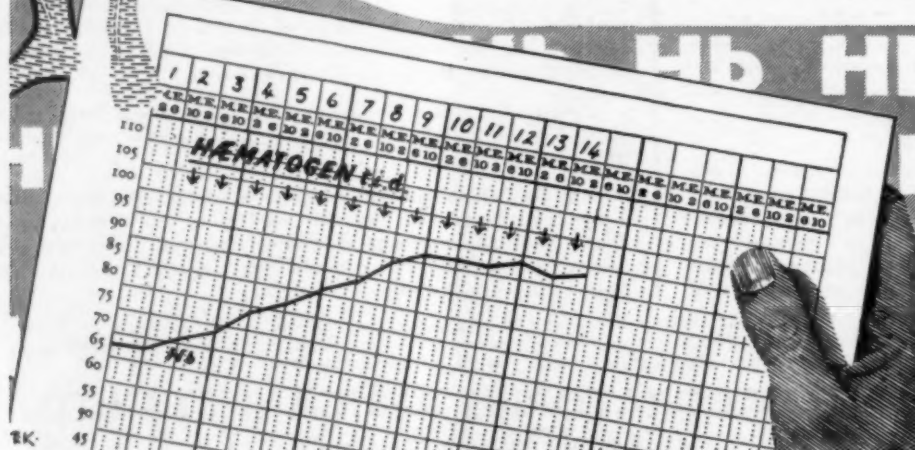
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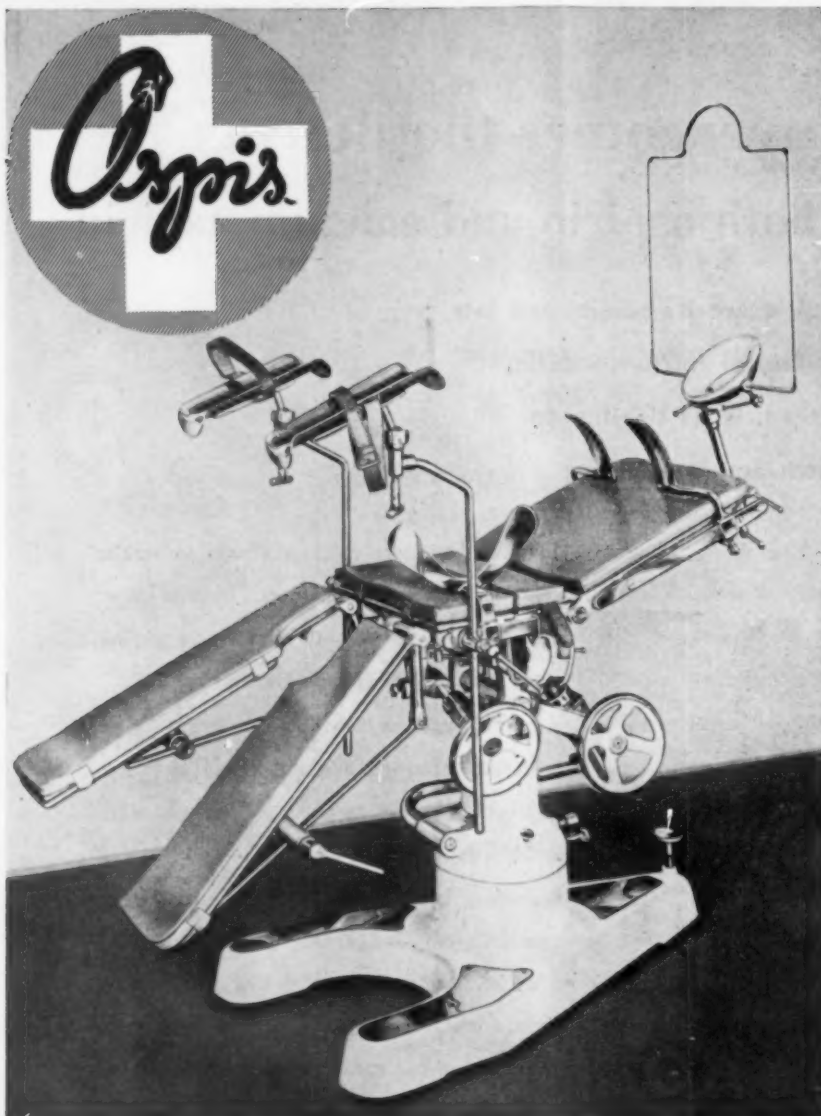
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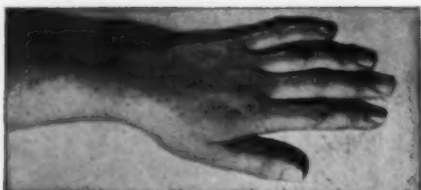
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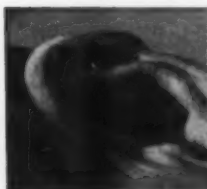
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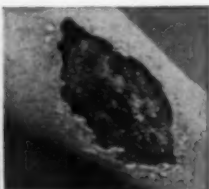
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Cape Town, 24 April 1954  
Weekly 2s. 6d.

Vol. 29 No. 17

Kaapstad, 24 April 1954  
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### EDITORIAL

#### THE ENLARGED PROSTATE

The subject of benign nodular hyperplasia of the prostate has recently been reviewed by Franks<sup>1</sup> at the Royal College of Surgeons of England. The enlargement of the prostate in this condition is due to hyperplasia of all elements of the inner group of prostatic glands. The presence of the testis is necessary for its development as shown by the fact that the disease is unknown in men who have been castrated in early life.

Within the prostatic capsule there are 4 groups of tissue: (1) the urethra, and its small evaginations; (2) the genital tract, including the ejaculatory ducts, the prostatic utricle and sometimes the lower ends of the seminal vesicles; (3) the peri-urethral glands; (4) the prostate proper.

The prostate is generally divided anatomically into 5 lobes—posterior, middle, anterior, and two lateral. From a study of glands injected with Indian ink by le Duc, and with latex or radio-opaque suspensions by Franks, it has been concluded that the prostate is composed of 2 major lobes (lateral lobes) and a small median lobe, sometimes replaced by a prespermatic commissure of interlacing lateral-lobe ducts.

Involution of the prostate begins early in adult life, as focal changes which later spread to involve the whole gland. It is hyperplasia of the inner group of prostatic glands, the set of fairly long-branched submucosal units and smaller mucosal short glands, that leads to benign enlargement of the prostate gland. It has however been claimed that the initial change occurs in the periglandular stroma near the urethra; fibromuscular nodules are believed to develop and to stimulate proliferation of gland epithelium, which then grows into the nodule from the periphery. It is still an open question whether the change begins in the epithelium or in the stroma. From the specimens he studied in his series Franks finds it impossible to state which element appears first in the nodules.

The presence of nodular hyperplasia alone does not necessarily cause urinary disturbance; some additional

### VAN DIE REDAKSIE

#### DIE VERGROTE PROSTAAT

Franks<sup>1</sup> het onlangs by die Royal College of Surgeons in Engeland 'n oorsig gegee oor die onderwerp sagaardige knoppieshiperplasie van die prostaat. Die vergroting van die prostaat in hierdie kondisie is aan oormatige groei van al die dele van die binneste groep prostaatkliere te wyte. Die aanwesigheid van die testis is noodsaaklik vir die ontwikkeling daarvan soos bewys word deur die feit dat hierdie siekte ongekend is onder mans wat op jeugdige leeftyd kastreer is.

Daar is 4 weefselgroepe binne die prostaatkapsel: (1) die urethra en sy klein uitstulpings; (2) die geslagstreek, insluitende die uitstortingsbuis, die prostaatsakkie en somtyds die laer ente van die saadblasies; (3) die peri-urethrakliere; (4) die prostaat self.

Die prostaat word ontleedkundig gewoonlik in 5 kwabbe ingedeel—die agterkwab, die middelkwab, die voorkwab en die twee sydelingse kwabbe. Uit 'n studie van kliere wat le Duc met Oosindiese ink ingespuut het en Franks met melksap of radio-ondeurskynende oplossings, is afgelei dat die prostaat ingedeel is in 2 hoofkwabbe (sydelingse kwabbe) en 'n klein middelkwab wat somtyds vervang word deur 'n voorafgaande saadverbinderbrug van aanmeakaargestregelde sydelingse kwabbuise.

Invulsië van die prostaat begin vroeg in die leeftyd van die volwassene as focale veranderinge waarin die hele klier op 'n later stadium verwickel word. Dit is die oormatige groei van die binneste prostaatkliergroepe, die groep subslymeenhede met hul taamlike lang vertakkings en die kleiner, kort slymkliere wat tot die sagaardige vergroting van die prostaatklier aanleiding gee. Aanspraak word eger gemaak dat die aanvangsverandering in die perikliersteunweefsel naby die urethra plaasvind; die mening is dat fibrosierknoppies ontwikkel wat klier-epiteelvermenigvuldiging stimuleer wat dan in die randknoppie ingroei. Dit moet nog besleg word of die verandering in die epiteel of in die steunweefsel begin. Franks vind dit onmoontlik om uit die monsters in sy serie wat hy bestudeer het vas te stel watter deel eerste in die knoppies voorkom.

Die aanwesigheid van knoppieshiperplasie alleen veroorsaak nie noodwendig urine-steurnis nie, een of ander addisionele faktor is ook nodig. Die grootte van die adenoomagtige knoppies verskil heelwat. Met 'n lykskouing kan 'n baie vergrote prostaat by mans gevind



factor is required. Considerable variation is found in the size of the adenomatous nodules. Great enlargement of the prostate may be found at autopsy in men who had no urinary disturbance during life. It has been suggested that the symptoms are perhaps due to interference with or pressure on nerves supplying the internal sphincter. Dysfunction of the sphincter rather than the size of the nodule would thus account for the urinary obstruction.

The cause of benign nodular hyperplasia is unknown and many views have been put forward to explain the origin. From animal experiments it would appear that administration of oestrogens can produce hyperplasia of epithelium, muscle, and fibrous stroma of the inner glands. It has been suggested, therefore, that the condition may develop in man from an absolute or relative increase of oestrogenic hormone.

The embryological origin of the inner group of glands might explain such a response to female sex-hormones. There seems to be no doubt that the prostatic utricle is derived from the Mullerian ducts, and is the homologue of the human uterus, but there is still much doubt about the fate of the lower end of these ducts and the origin of the prostatic glands. Whatever the origin of the whole inner prostatic area, the response of its constituent tissues to the stimulus is hyperplasia, and animal experiments point to oestrogen as the stimulus.

There is still room for histochemical and experimental work in the study of the aetiology, prevention and treatment of benign nodular enlargement of the prostate.

#### REFERENCE

1. Franks, L. M. (1954): *Ann. Roy. Coll. Surg., Eng.*, **14**, 92.

#### GENERAL PRACTICE

General practice and the general practitioner are not only the foundation on which the whole structure of medical practice is based, but they constitute the major part of that structure. Medicine as a whole will remain in a sound condition only so long as general practice is sound. In recent years, both in South Africa and other countries, there has been misgiving concerning the status of the general practitioner and the past and future trend of general practice. It is a matter of vital interest to the profession of medicine and the community as a whole.

Dr. Stephen Taylor, under the auspices of the Nuffield Provincial Hospitals Trust, has recently made an investigation into the conditions under which general practitioners in England are practising, and the report of his survey has now been published in a book of 604 pages, of which a short summary is published in this issue of the *Journal* (page 363). Conditions of general practice in England naturally differ from those in South Africa. Except perhaps in some of our larger cities, medical practice is less differentiated than in England as between general practitioners and specialists, and the absorption of English doctors into the British National Health Service brings about other important differences between the two countries. Nevertheless

word wat nooit gedurende hul leeftyd enige urine-sternis ondervind het nie. Die mening is uitgespreek dat die simptome miskien te wyte is aan inmenging in of drukking op senuwees wat die inwendige sluitspier voorsien. Die abnormale werking van die sluitspier eerder as die grootte van die knoppie sou dan vir die urine-versperring verantwoordelik wees.

Die oorsaak van sagaardige knoppieshiperplasie is onbekend en baie menings is uitgespreek om die oorsprong te verklaar. Uit proefnemings met diere blyk dit asof die toediening van estrogene, hiperplasie van die epiteel, die spier en die veselagtige steunweefsel van die binneste klier-groepe kan veroorsaak. Die opinie is derhalwe geopper dat hierdie toestand by mans kan ontwikkel as gevolg van 'n absolute of relatiewe vermeerdering van estrogeenhormone.

Die embriologiese oorsprong van die binneste groep kliere kan moontlik so 'n reaksie op die vroulike seks-hormone verklaar. Daar bestaan geen twyfel nie dat die prostaatsakkie van die Mullerian-buise afkomstig is nie, en dat dit met die menslike uterus ooreenstem nie, maar daar bestaan nog baie twyfel oor die lot van die laer ente van hierdie buise en die oorsprong van die prostaatkliere. Wat ookal die oorsprong van die hele binneste prostaat-opervlakte mag wees, is hiperplasie die reaksie van dié oppervlakte se saamstellende weefsels op die stimulus en proefnemings met diere wys na estrogeen as die stimulus.

Die studie van die etiologie, voorkoming en behandeling van sagaardige knoppiesvergroting van die prostaat vereis dat meer aandag nog aan weefselchemieë en proefnemings op hierdie gebied geskenk moet word.

#### VERWYSING

1. Franks, L. M. (1954): *Ann. Roy. Coll. Surg., Eng.*, **14**, 92.

medical practice necessarily has much in common all the world over, and the British survey will be read with interest in this country.

The results of the survey on the whole are regarded as satisfactory, though there is a good deal of variation in the conditions under which practice is conducted. They are commonly lower in the poorer districts. It is suggested that the basic unit of accommodation for a general practitioner should be a minimum of 3 rooms—waiting-room, consulting-room and examination-room—and importance is attached to the question of auxiliary assistants, especially secretarial.

The rota system is growing, whereby several practitioners come together so that at nights and week-ends one or two go on duty for all, and this development is favoured both by doctors and patients. A study is also made of group practice.

The attendances by the individual doctor, whether on a visit or in the surgery, were found to vary from an average of 24 a day to an average of 87. It is concluded that the optimal maximum panel list of a general practitioner should be between 2,500 and 3,000 (the legal maximum is 3,500). The attendances (on visit or in the surgery) ranged from 3.5 to 8.7 a year per person



(average 5). These differences depend on the amount of ill-health in different parts of the country, on individual sickness-proneness, and on the varying tendency of individuals to call in the doctor.

It is interesting in view of the fact that so much has been heard on the subject of the paper work that doctors are required to do under the British NHS that no

serious complaints on this subject were encountered in the survey. It was concluded that well-kept records were of great importance from this point of view.

One half of the general practitioners visited held hospital posts. Expression is given in the report to the value of this as a stimulus to practitioners to keep up to date and to its value in other respects.

## MASS X-RAY SURVEY: BECHUANALAND PROTECTORATE 1952

M. SCHECHTER, M.B., B.Ch.

*Union Health Department*

*Council for Scientific and Industrial Research, Research Unit in Tuberculosis*

*King George V Hospital, Durban*

In September 1952 a mobile miniature mass X-ray unit (General Electric) of the Union Health Department was sent to Bechuanaland Protectorate for a tuberculosis survey. It was the first time in the history of the Protectorate that an investigation of this nature had been undertaken.

The Protectorate has an area estimated at 275,000 square miles and an average altitude of 3,300 feet. The country is extremely dry except in the north-western part, which is served by the Okavango river. The average rainfall is about 18 inches a year, which may be compared with that of the Kalahari (10-11 inches). According to the 1946 census the population was: Europeans 2,325, Asiatics 96, Coloured 1,708, Africans 292,754. The country is essentially pastoral. The Natives are mainly engaged in cattle rearing and in 1951 there were 1,025,845 cattle and 673,069 sheep and goats. Maize, kaffir-corn-beans, pumpkins and melons are grown.

The Bechuana are of Bantu stock and speak Sechuana. There are 8 main tribes—Bamangwato, Batawana, Bakwena, Bangwaketse, Bakgatla, Bamalete, Barolong and Batlokwa; and a fair cross section of most of these was obtained.

The survey was of an epidemiological nature to ascertain the incidence of pulmonary tuberculosis in the rural community of Bechuanaland. Any other abnormalities found in the chest were also noted. A routine Mantoux test, using .0002 mg. purified protein derivative, was performed on every individual and the height and weight of every examinee was taken. Where possible, sputum tests were done in cases which showed radiological evidence of pulmonary tuberculosis, and all interesting lesions of eyes, skin, ears, teeth etc. were photographed in colour. A documentary film in colour was also taken of the survey.

The team consisted of a doctor, a radiographer, an electrician, a driver and an African lorry boy and these were supplemented in the Bechuanaland Protectorate by 5 more Africans. The team was given a caboose and a lorry by the Bechuanaland Protectorate Government for sleeping accommodation and to carry supplies—particularly petrol. The mass X-ray unit carried its own generator, from which it was possible to run the X-ray

plant, lights, sterilizer, cine-projector, corico camera, etc.

Fig. 1 shows a map of the area covered and the route taken. The survey commenced at Lobatsi and extended up the main Mafeking-Francistown road going about 40 miles inland for 2-3 weeks at a stretch. The villages visited and the number of X-rays done at each village were as follows:

	Examinees
Lobatsi	— 873
Moshupa	— 500
Kanye	— 5000
Moshaneng	— 320
Gaberones	— 1858
Mogoditshane	— 414
Mochudi	— 1462
Molepolole	— 5592
Ramoutsa	— 2858
Thamaga	— 789
Francistown	— 700
Mafeking	— 800

Serowe and other villages in the Bamangwato reserve were left out.

Propaganda had already been showered on the Africans and the co-operation of the chiefs had been enlisted by the Medical Director and his staff. This was supplemented by open-air movie shows and public addresses to the people by the chief, the district commissioner of the village and the doctor at points of congregation such as water holes and *kgotlas*. Two of the chiefs, one at Ramoutsa and one at Molepolole, conceived the bright idea of instructing their personal musicians to play at the van in order to attract the crowd. The music was interrupted from time to time and the chief would address the crowd and urge them to have an X-ray. This was highly successful, and we had a big response at these two villages.

*Procedure.* After a suitable site had been chosen for the X-ray van to stand at, and camp set up, the villagers were asked to present themselves at the X-ray van. The lower age-limit was 4 years, because of the difficulty of X-raying younger children. The day organized for each section of the village was regulated according to the borehole from which the people drew their water.

The name, age and sex of the examinees was taken by



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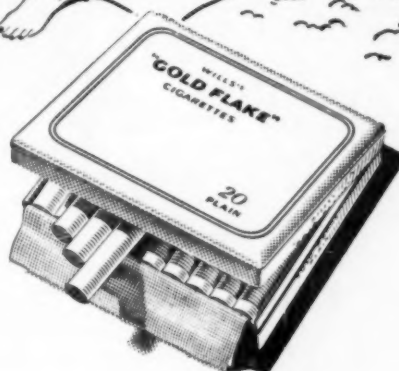
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then X-rayed on the unit and at the end of the day's work the spools were developed and the films interpreted.

*X-rays.* 21,270 70-mm. X-rays were taken and below is a list of the abnormalities found.

	Cases
Active pulmonary tuberculosis .. ..	273 (1.3%)
Enlarged heart or abnormal cardiac silhouette ..	287
Aneurysm of aorta (included in foregoing) ..	93
Old pulmonary tuberculosis (inactive) ..	33
Haziness at both bases with shadows suggestive of bronchiectasis .. ..	51
Thickened pleura .. ..	44
Mottling of both lung fields .. ..	20
Widened mediastinum (probably glands) ..	84
Emphysema marked .. ..	1
Shadow at right base of doubtful nature ..	15
Pneumothorax .. ..	1
Pneumonia (coccal) .. ..	12
Achondroplasia .. ..	1
Lung abscess (coccal) .. ..	4
Retrosternal thyroid .. ..	3
Primary complex .. ..	19
Carcinoma of lung? (erosion of rib) ..	1
Herniation of stomach through diaphragm ..	1
Tumours and cysts .. ..	21
Cystic disease .. ..	1
Disease of spine: kyphosis and scoliosis ..	14
Shadows, probably outside thorax .. ..	9
Calcified mediastinal glands .. ..	16
Dextrocardia .. ..	9
Cervical ribs .. ..	10
Pleural effusion .. ..	8
Pericardial effusion .. ..	3

It will be noted that the incidence of active pulmonary tuberculosis was 1.3%.

*Sputum Testing.* Because of the difficulty of getting examinees back again, not many sputa were tested. Random samples of sputa were taken from 273 persons who showed radiological evidence of active pulmonary tuberculosis. Of the few sputa examined tubercle bacilli were present in a high percentage of cases. This was on direct microscopy; no concentrations or cultures were done.

In view of the very small percentage of cases showing radiological evidence of tuberculosis with a negative sputum in this survey and experience in other surveys, we have based our figures for active pulmonary tuberculosis on the X-ray findings.

All the examinees who returned for sputum-testing had a cough, were losing weight and were generally debilitated.

The type of pulmonary tuberculosis did not vary much from village to village.

The incidence of cases showing enlarged hearts or abnormal cardiac silhouettes was also 1.3% of total number of cases X-rayed. Of these, 93 (32%) were cases of aneurysms of the aorta. Because of the high incidence of positive Wasserman reactions it was assumed that most of these were syphilitic.

#### TYPE OF PERSON X-RAYED

The age groups of the Natives X-rayed is shown in Fig. 2. It will be noted that there were more of school-going age and over 40. This is accounted for by the exodus of younger adult males to the gold mines and to the fields.

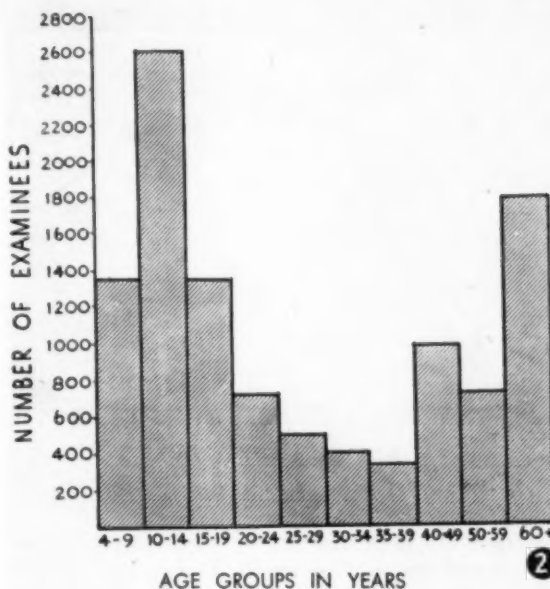


Fig. 2

Of the 21,270 examinees seen 13,540 were females and 7,460 males. The disparity was most marked in the 20-40 age-groups, where the ratio of females to males was about 4 : 1.

The prisoners at Gaberones, Kanye and Molepolole were included in the survey. A few cases of active pulmonary tuberculosis were found in this small group.

The diet of the people was very poor in protective foods. It contained very little protein. The cows produced no milk because of the drought which was prevalent during the survey, the people were not eating eggs from their poultry, and the only time any meat was eaten was when animals died or were slaughtered at festivities. Wealth in the Bechuanaland Protectorate is measured by the number of cattle owned, and the owners are very reluctant to part with livestock.

#### MANTOUX TESTING

All examinees were Mantoux-tested with .0002 mgm. of P.P.D., freshly prepared daily and kept under refrigeration. The left forearm was chosen as the site for injection and was cleaned with ether swab before the test was performed. The tests were interpreted after 72 hours or later.

Of the total number done (21,270) 10,401 returned to have the test interpreted. This was quite a good return considering the long distances. Of the 10,401 6,910 were females and 3,491 males.

A small plastic ruler was used to measure the size of the induration of the reactions.

The results are analysed in Figs. 3, 4 and 5.

In Fig. 3 an induration of 7 mm. is taken as a positive reaction. In the 5-9 years age-group the reactors were 44% in males, 50% in females and 47% in the sexes



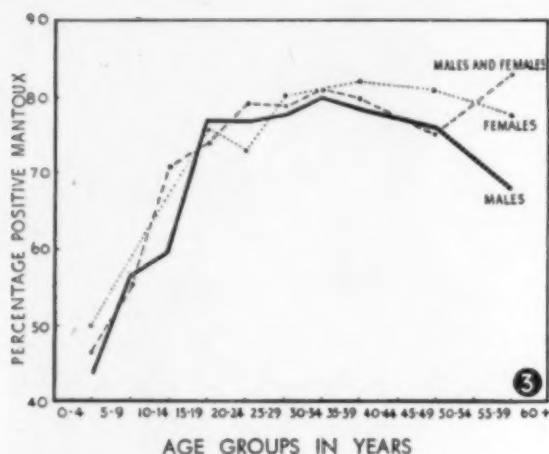


Fig. 3

together. It will be seen that the graph ascends, reaches a peak, and then slowly descends. This may be explained by the fact that the older age-group are from another generation. The highest positive figures reached in adult age groups were: males 80%, females 82%.

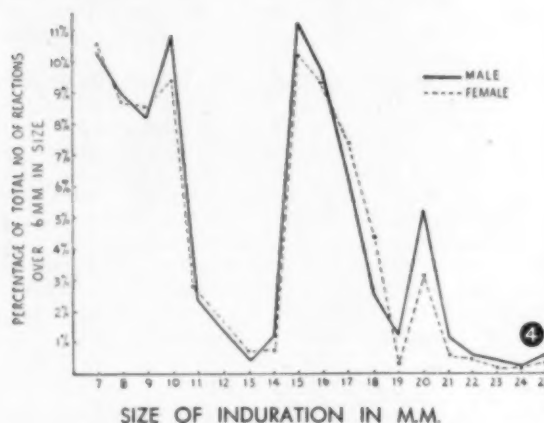


Fig. 4

The sizes of reactions are shown in Fig. 4. Of the total number measured 10.5% were 7 mm. in size, 10.6% 10 mm. and 11.2% 15 mm. The largest reaction measured was 50 mm. in size.

From the graphs it will be seen that the peaks are at 7, 10, 15, 20, 25 mm. respectively, and the depressions at 9, 13, 19 mm. The peaks and depressions were probably artificial, caused by a personal bias, conscious or unconscious. Thus 7 or 10 mm. appear to have been preferred to 9, and 10 or 15 mm. to 13.

Allowing for these errors Fig. 5 shows the mean

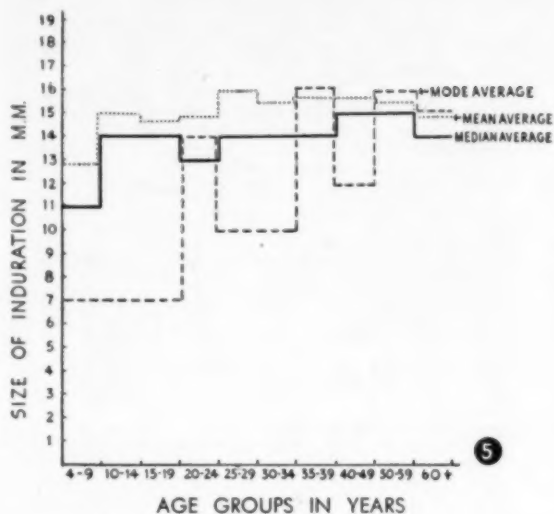


Fig. 5

average, median average and mode average for the individual age-groups. The mean average size for all age-groups was 15.3 mm. and the median average 14 mm.

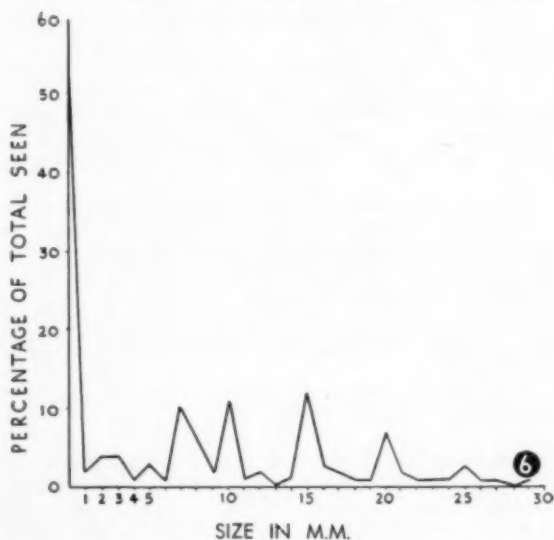


Fig. 6

In a small number of all age groups, all reactions were measured from 0 upwards (see Fig. 6). About 48% show no reaction at all. The graph then drops steeply and rises again at the peaks referred to in Fig. 4. There is an obvious change in the curve at the 6-7 mm. stage.

## OTHER CONDITIONS

**Deficiency Diseases.** There were many cases seen of B deficiency. They presented signs of dry skin, pavementing of epithelium, 'butterfly pigmentation' on face and glossitis. The diagnosis of pellagra was not accepted by Dr. Squires of the Bechuanaland Protectorate Medical Services.

**Scabies** was very prevalent. Regular washing of the body is not always possible because of the scarcity of water, and the people slept in close proximity to one another. In a school of about 300 pupils, 70 had obvious scabies.

**Hernias.** A large number of umbilical hernias were seen, a few assuming huge proportions. This is attributed to the *Tswana* custom of dealing with the umbilical cord. Sepsis in the umbilical stump is very common and this leads to weakening of the abdominal wall.

**Witkop.** The condition of witkop was common in villages we visited. It was first described by McArthur and Thornton in 1911. The disease commences by the appearance of macules on the scalp. These develop through various stages, forming white yellowish crusts which coalesce until finally the scalp is covered by a thick white cap as the name implies. The condition is always accompanied by syphilitic stigmata and yields to arsenical treatment. Fig. 7 shows an example.



Fig. 7

**Eye Infections.** Trachoma was quite common and we saw a few cases. An eye survey had been conducted in Kanye and the incidence of trachoma was found to be high. The incidence of acute coccal conjunctivitis was also high, most of the staff of the unit being afflicted. This is attributable to the dust and flies.

**Intestinal parasites and amoebiasis** are rare because of the dry climate.

**Scurvy.** No scurvy was seen, except one case in hospital.

**Endemic Extraveneal Treponematoses** (known as *bejel* in Egypt) is common in the Bechuanaland Protectorate. We saw a few cases of it. The Bakwena call it *Dichuchwa*.

## THE COMPARISON OF HEIGHTS AND WEIGHTS ON A BASIS OF AGE

Heights and weights were measured on a brass steelyard Avery scale with sliding poise. They were not taken in

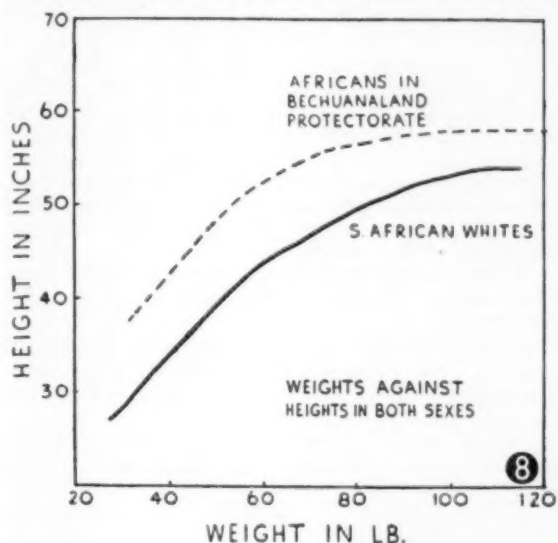


Fig. 8

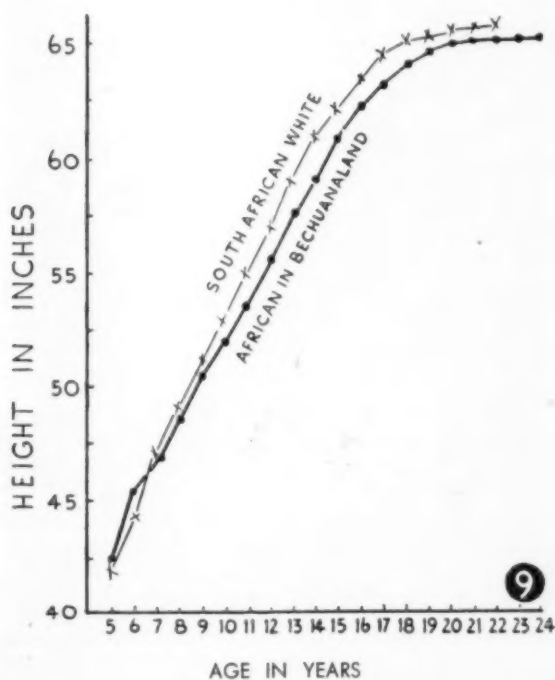


Fig. 9

the nude. Children usually wore a small *muchi* (loin cloth) and adults were weighed in clothing, which usually did not amount to more than a few pounds. Thus the weights of the children will be more accurate than those of the adults. Weights were measured to the nearest lb. and heights to nearest  $\frac{1}{4}$  inch. Weight against height is shown in Fig. 8 for over 21,000 Natives.

Our lower age-limit for examinees was 4 years and there was no upper limit. The ages are not accurate, there being a latitude of 2 years either way in all school-going ages. Ages were usually obtained from parents or from school teachers and where neither source was available an estimation from physical development was made. Although comparisons of age, height and weight are most valuable in pre-school age and school age. Older age-groups are included.

It will be seen that in comparison with European children the African child in the Protectorate is far thinner.

Age against height is shown in Fig. 9 for over 21,000 Natives. The European child in the Union seems to grow quicker than the African child in the Protectorate and also seems to reach a greater height. This is shown by Fig. 9 which compares height against age in over 21,000 persons seen.

#### SUMMARY

In a survey in Bechuanaland Protectorate in 1952, 21,270 examinees presented themselves for (1) X-ray of chest, (2) Mantoux test with .0002 mgm. P.P.D., (3) heights and weights, (4) sputum tests.

*X-rays.* 273 showed signs of active pulmonary tuberculosis (1.3%), and 287 showed abnormal cardiac silhouettes.

*Mantoux.* The test was interpreted after 72 hours in the 10,401 who returned to have the reaction noted. In the adult age-groups 81% showed positive reaction. The mean average size of the reaction for all age groups was 15.3 mm. The median average was 14.0 mm.

*Sputum Tests.* Many of the cases showing radiological evidence of active disease had tubercle bacilli in the sputum on direct microscopy: No 'concentration' was done.

*Heights and Weights.* The Bantu child was not as heavy as the South African European child and not so tall.

This survey was carried out by the Union Health Department's mass X-ray unit and team at the request of the authorities of the Bechuanaland Protectorate.

## ACID BURNS OF THE STOMACH

SAMUEL SKAPINKER, M.B., B.Ch. (RAND), F.R.C.S.E.

and

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Upper gastro-intestinal strictures caused by caustics are not uncommon, and in these pyloric obstruction occurs in 20% of cases. Marchand<sup>1</sup> recently studied 74 cases of caustic strictures of the oesophagus and found that in only 4 were there gastric lesions. He also observed that although the stomach is frequently affected this is not always appreciated because in the cases that survive the initial onslaught the degree of fibrosis that develops is insufficient to cause any symptom. Burns by corrosive acids have the reverse effect, for the oesophagus escapes in 80% of cases and the main site of stricture is the pylorus.

Acid burns of the stomach are not common and only about 140 cases have been reported.<sup>2</sup> Books on surgery and toxicology are singularly lacking in any description of this condition.

*Pathology.* The type of corrosive taken has a distinct bearing on the position of the stricture. In cases where acid has been swallowed the oesophagus escapes and there is a marked effect on the stomach. Delore and Armand<sup>3</sup> have shown that acids in 'normal' concentration during their rapid passage through the oesophagus have a superficial scorching effect on the squamous epithelial lining. The simple columnar epithelium of the stomach however is quite readily corroded by acids. The fact

that the acid is retained in the stomach increases this effect. Orator<sup>4</sup> found that in 34 cases with late gastric sequelae only 7 had associated oesophageal lesions.

Caustic soda on the other hand has a universal colliquative action irrespective of the tissue, so that the oesophagus and stomach are equally affected, the former more so, because dilution does not occur.<sup>2</sup>

The amount the stomach contains at the time the acid is taken is important; if the stomach is empty the effects are far more severe than if it is full. A small quantity of acid in an empty stomach may cause extensive necrosis and scarring. The usual effect of the acid is to cause necrosis, and the stomach when seen in this phase at post-mortem is black, necrotic and oedematous. Perforation is apt to occur, with fatal peritonitis. When the trauma is less severe scarring occurs, and this may vary from pyloric obstruction or hour-glass constriction to linitis plastica of the stomach.

Waldyer<sup>10</sup> and Aschoff<sup>11</sup> explain that when the stomach is full the ingested corrosive fluid passes rapidly through the oesophagus along the lesser curvature of the stomach to the pylorus, where it spreads out in the shape of a triangle with the base towards the pylorus and the apex towards the cardia; this results in pylorospasm and contracture of the lesser curve causing a short stomach.

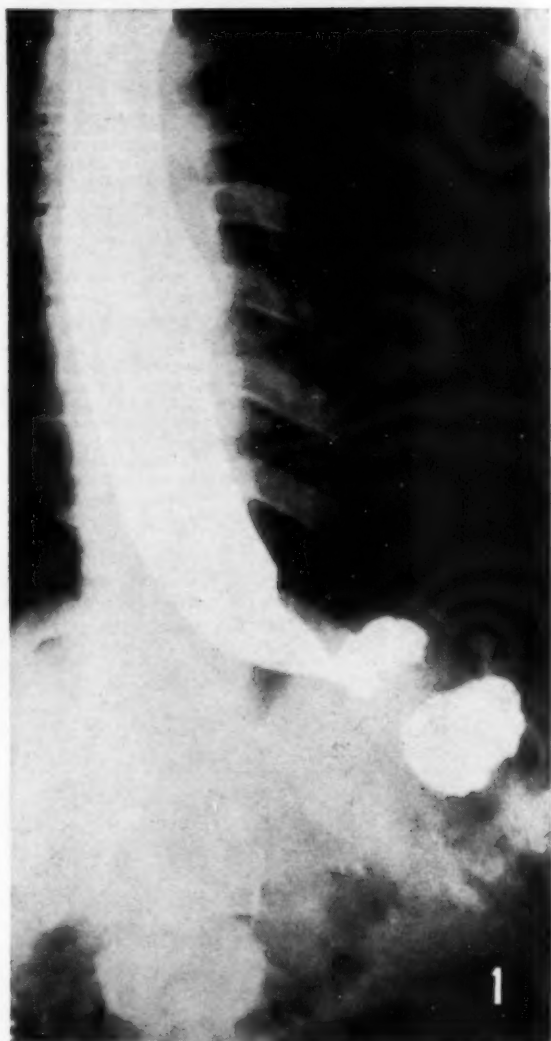


Fig. 1. Barium swallow showing normal oesophagus with stricture-formation at the distal end and marked strictures of the stomach.

The greater curvature is protected by the food in the stomach. In the empty, contracted stomach, the lesser curve is vertical and the acid comes in contact with the whole gastric mucosa. The result is extensive ulceration and total gastric scarring, as occurred in our case.

Elisher<sup>5</sup> pointed out that the number of patients who die of a perforated gangrenous stomach due to sulphuric acid is considerably higher than with hydrochloric acid. Nitric acid and trichloroacetic acid have also been reported to have caused pyloric obstruction.<sup>6</sup>

**Diagnosis.** This is usually made on the history; but in some cases—suicides and alcoholics—the patient may not admit having taken acid when seen in the stage of

fibrosis, and the condition may be mistaken for a carcinoma of the stomach.<sup>7</sup> The acid most commonly taken is hydrochloric acid; less frequently sulphuric acid. It may be taken accidentally or with suicidal intent.

Hydrochloric acid, commonly known as 'soldering fluid', is used by plumbers and other industrial workers, and because it is a clear fluid may be mistaken for water, and occasionally for whiskey according to some American authors.

**Symptomatology.** In the acute case, the patient experiences a severe burning taste in his mouth, throat and abdomen. Vomiting is profuse and the patient is shocked. The inhalation of fumes causes coughing and oedema glottidis. Death may be due to shock or asphyxia, or, if the patient survives these, perforation and peritonitis. Later, if he recovers from the acute phase, cicatrization of the stomach is rapid and the patient then presents with marked wasting, dehydration and inability to eat. The weight loss is profound and dehydration is marked.



Fig. 2. Barium meal shows the marked deformity of the stomach, with marked constriction and shortening of the lesser curvature. Note the normal-looking pylorus and duodenum.





Fig. 3. Stomach after removal. Note its small size.

Cases occur at all ages. (One child aged 2 took 20-40 ccs. of concentrated hydrochloric acid. In this case the initial symptom was haematemesis. There were then no symptoms for 2 weeks and the child then started to vomit. X-rays 7 weeks later showed a complete absence of the gastric lumen. Total gastrectomy was performed with satisfactory early result.<sup>3</sup>)

**Treatment.** The first-aid treatment is to give these patients alkalis. Alkaline carbonates should be avoided as they may cause gross distension. Stomach washouts should be avoided as the stomach at this stage is black, oedematous and friable. Symptoms, such as oedema glottidis, should be treated as they occur. It has been suggested that an emergency jejunostomy should be performed and antibiotics should be administered in large doses.

After the acute phase has passed, the patient should be rested for 2 weeks and then X-rayed at regular intervals for sequelae. If only a pyloric obstruction results, partial gastrectomy should be done; gastro-enterostomy has been tried and found to be unsatisfactory owing to the state of the stomach wall. If a linitis-plastica type of lesion has occurred a total gastrectomy will have to be performed.

#### CASE REPORT

E. M., a 34-year-old Xhosa male was admitted to Baragwanath Hospital on 27 August 1953 with a history of persistent vomiting for one month. Two and a half months previously this patient, who is employed in a garage, accidentally swallowed 'soldering fluid', which he mistook for medicine, 4 hours after his evening

meal. The quantity swallowed was 2 oz. concentrated hydrochloric acid. He coughed and vomited immediately afterwards and was taken to the clinic, where emergency first-aid measures were taken. The vomiting started one month before admission and he suffered a marked loss of weight. On admission he was only able to eat very small quantities of food.

On examination he was found to be very emaciated and ill-looking. Dehydration was profound and he was extremely weak. Apart from the wasting, nothing was found on examination of the abdomen except slight tenderness in the epigastrium.

Oesophagoscopy was done on 29 August by Dr. J. C. van der Spuy, who saw no abnormality with a 40 cm. oesophagoscope. A stricture was encountered with a bougie below this level, and was dilated to size F. 22 without any difficulty. This was followed by a barium meal, when X-ray showed marked scarring of the stomach and a stricture at the oesophago-cardiac junction (see Figs. 1 and 2).

The patient was prepared for operation by correcting his dehydration, sodium deficiency and protein deficiency.

**Operation.** On 2 September under general anaesthetic a thoraco-abdominal incision was made through the 8th interspace and continued as a transverse incision across the abdomen. The diaphragm was divided and the stomach was found to be contracted, measuring 12½ cms. in length and 4½ cms. in diameter. A total gastrectomy was performed. Figs. 4 and 5 show the stomach as it was after removal. The patient now enjoys his meals and there is a complete absence of dumping.

A method we consider valuable in reconstituting continuity after total gastrectomy was used and we feel that it should be given some attention. After the duodenum is sectioned, it is closed by the usual method. The

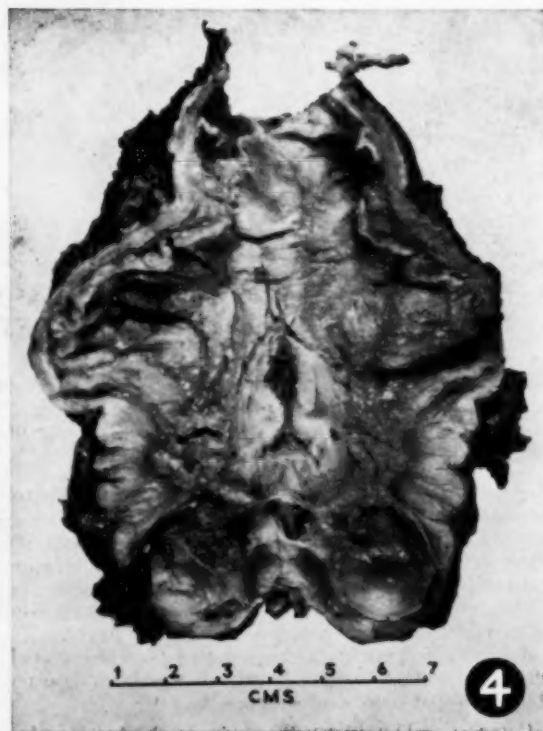


Fig. 4. Stomach opened, showing marked scarring and destruction of the mucous membrane.





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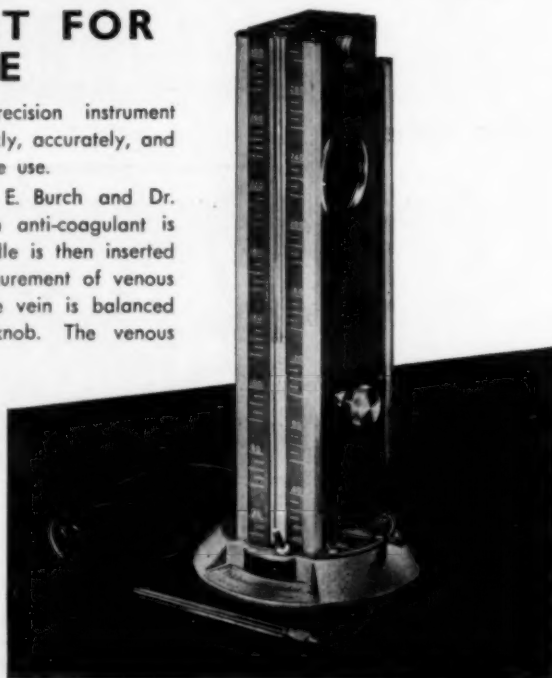
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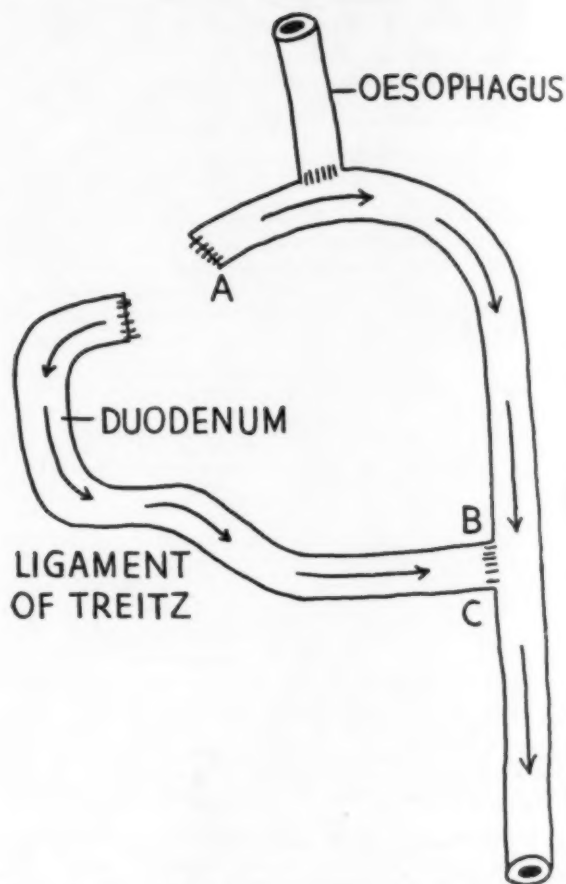


Fig. 5. Diagram to illustrate the reconstruction after total gastrectomy: (a) is the severed distal end of (b) (b) is anastomosed again to jejunum at (c).

jejunum is then sectioned 10 inches from the ligament of Treitz. The distal limb is closed and drawn through an opening in the transverse mesocolon so that 6 inches of it lies proximal to the oesophagus. An end-to-side anastomosis is then performed (See diagram in Fig. 5). A Roux-en-Y anastomosis is done between the proximal jejunal loop.

This procedure was demonstrated recently to one of us (S.S.) by Mr. R. C. B. Ledlie of London, and in the two cases where we have used it the striking feature was the absence of the dumping syndrome.

#### SUMMARY

1. Lesions of the stomach caused by corrosive acids are discussed.
2. Symptomatology, diagnosis and treatment of the condition is given.
3. A case report is presented.
4. A method of reconstructing intestinal continuity after total gastrectomy is reported.

We must thank Dr. J. C. van der Spuy for his assistance of this case and the care he took in the post-operative treatment, Dr. J. D. Allen, superintendent, Baragwanath Hospital for his permission to publish this case and Mr. T. Marais for the photographs of the specimen.

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## ON THE TREATMENT OF THE UMBILICAL CORD IN THE NEW-BORN

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Cape Town

The services of nurses are nowadays at a premium, and any measure which eliminates unnecessary work for them justifies itself. Such a measure would be the elimination of daily cord dressing in the newborn, which is time-consuming and also involves the use of materials which have to be prepared by the nursing staff.

It is not a new idea<sup>1</sup> to leave the cord uncovered, but nevertheless the change is likely to be opposed on conservative grounds. One very important objection was

raised—that cords which were not dressed took longer to fall off. If this were true it would be a major objection, for the most economical use of hospital beds is obligatory; and the discharge of a baby from hospital before the separation of the cord is not advisable, unless a home-nursing service is available.

The purpose of this paper, therefore, is to report an experiment to prove or disprove whether uncovered cords take longer to separate, and to study the possible ill-effects on the babies so treated.



## THE INVESTIGATION

The investigation was conducted in a non-European maternity hospital, under the supervision of three European sisters, but with routine nursing being done by non-European staff. About 60% of the patients are Cape Coloured and 40% are Africans.

The babies were divided into two groups. The first were controls with daily cord dressings. It was intended to give the second group no further treatment than an initial swabbing with methylated spirits; but there commonly took place an invasion of saprophytic organisms with their characteristic odour, and it was thought that, though no inflammation occurred, it would be impossible to convince the staff and others that such objectionable odour was harmless. Accordingly, in the later cases of the second group the cord was swabbed each day with methylated spirits, and this abolished any unpleasant smell.

Group A comprised those 1,019 babies whose cords were dressed daily with cord dressing and zinc and

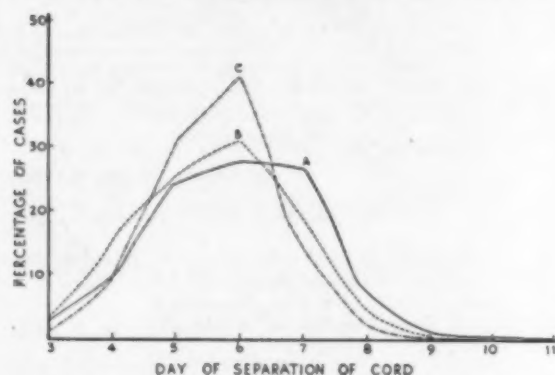


Fig. 1.

starch powder, and around whom binders were secured. Group B, of 335 babies, were swabbed initially with methylated spirits and untouched thereafter, and Group C, of 556 babies, were swabbed daily with methylated spirits. No binders were applied in Groups B and C.

The swabbing was done very gently and a soaked swab was squeezed to saturate the stump and the navel.

In all cases a ligature was applied at birth and a second one on return to the ward, when the initial swabbing or dressing was done. A third ligature was applied if the consistency of the cord indicated the risk of the ligature slipping with shrinkage of the cord, and a haemorrhage occurring. If unduly exuberant, the granulating surface left after the separation of the cord, was touched with a copper sulphate crystal.

**Day of Separation of the Cord.** The three curves in the graph depicted in Fig. 1 show for these three groups the percentage of cords separating on any one day. The first day of life is taken as the day of delivery for babies born before noon; but for babies born after noon, the morrow is taken as the first day. Assuming an even distribution of births, the average age of those born before midday will be 18 hours on entering the second

day of life; whereas those born after midday will average 30 hours. No correction is therefore necessary.

	Male	Female
A. Cord dressed daily with zinc and starch powder — 1019 cases	490	529
B. Cord swabbed initially with methylated spirits — 335 cases	166	169
C. Cord swabbed daily with methylated spirits — 556 cases	283	273

Table I sets out the exact figures and their sex distribution. Group A consists of the deliveries for a whole year and there is no significant difference between the time of separation of the cord in the sexes, although it may appear that there is a predominance of one sex for a given day.

TABLE I. DAY OF SEPARATION OF CORD ACCORDING TO METHOD OF TREATMENT OF CORD, AND BY SEX

Day of Separation of Cord	A Daily Zinc and Starch Dressings		B Initial Swabbing only		C Daily Swabbing	
	M.	F.	M.	F.	M.	F.
3	11	17	4	6	3	3
4	53	47	22	30	22	32
5	113	136	39	47	86	86
6	131	153	61	43	128	100
7	133	141	29	36	36	42
8	40	31	8	7	8	6
9	8	1	3	0	0	2
10	1	2	0	0	0	2
11	0	1	0	0	0	0
Totals	490	529	166	169	283	273
Totals	1,019		335		556	
Mean Day	5.928		5.654		5.68	
Standard Deviation	1.256		1.217		1.023	

It will be seen that the mean day of separation of the cord is higher in Group A than Group B or C. By calculation of the standard error it is shown that the observed difference between the means of A and B is 3.5 times the standard error, and between Groups A and C, 4.2 times the standard error. The result is therefore significant and indicates that in both B and C groups the cords probably separated earlier than in Group A. There is no significant difference between Group B and C.

**Sepsis.** No inflammation of the umbilicus occurred in any case in any group. The cord normally separates to leave a granulating area at the umbilicus, which is covered by epithelium in a few days, and this area, until epithelialized, is more vulnerable than the unseparated cord.

In view of the fact that male new-born children not uncommonly urinate upwards towards the head, a careful watch was kept on them in case the cord should become soaked with urine. Being wet, it would have provided a better nidus for infection.

In Group B, when no treatment was undertaken after the first day, no difference was found in the incidence of saprophytic odour between boys and girls. Possibly the use of a binder would have altered this finding by allowing stagnant urine to accumulate on the abdomen, but the napkin appears to be an efficient barrier, even if,

as in this series, it is only changed at feeding times at 4-hourly intervals.

It seems that daily swabbing with methylated spirits is sufficient to prevent infection. Although Group B is a small group, any tendency to infection would probably have been disclosed.

The practice of cutting short the cord to  $\frac{3}{4}$ -1 inch and sealing once with collodion<sup>1</sup> may be preferable in even further reducing the handling, but has the disadvantage that the granulating area left during separation remains unprotected and untreated.

**Haemorrhage.** Haemorrhage from the cord may occur either in the first few hours from the umbilical vein, following insecure obliteration by a ligature, or after 24 hours with haemorrhagic disease of the new-born and possibly a small associated injury at the base of the cord.

Despite the exposure of the cord to the movements of the child and the rubbing against the clothes, no haemorrhages were seen. None were seen in Group A either.

#### CONCLUSION

In an institution it is desirable to dispense with the use of cord dressings and binders as an unnecessary nursing imposition without benefit to the baby. The objection that cords dressed daily and with binders applied separate earlier than those not so dressed, is ill-founded; and in fact the opposite is the case.

The conclusion cannot be directly applied at present to domiciliary practice, where a change of routine is likely to be blamed for any accident in the new-born period. Nevertheless, the daily application of methylated spirits as a hygienic measure would appear to be preferable to the sprinkling of non-sterile powder. It is a simple

measure, and it should be possible to instruct even ignorant mothers in thus caring for the unseparated cord, and by continuing the treatment to eliminate the risk of invasion by organisms through the granulating area left after the separation. This would permit of earlier discharge from hospital, even in those areas where no home-nursing service is available for the babies who are discharged with the cord unseparated.

An exception may perhaps be made in cases where it is foreseen that the infant may need an exchange transfusion. Thus if the mother is known to be Rh negative, or there is a risk of other haemolytic disease of the new-born, it is better to use normal saline dressings to preserve the cord. It is, however, possible to cut the cord flush with the abdominal wall and perform a satisfactory blood transfusion, even if the cord is withered.

#### SUMMARY

1. There is no evidence of increased risk of sepsis or haemorrhage following on exposure of the umbilical cord and the avoidance of cord dressing and binders, when daily swabbing with methylated spirits after the bath is done.

2. Such a procedure results in a separation of the cord earlier than with the usual method of dressing, powder and binder.

3. The nursing staff are emphatic that much time, labour and materials have been saved.

I am indebted to the Matron and Staff of the Salvation Army non-European Maternity Hospital for their co-operation, and to Miss P. Duncan who extracted the figures.

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## AGRICULTURAL FOUNDATIONS OF NUTRITION

### IV. SOME OTHER BASIC ASPECTS OF FOOD PRODUCTION

F. W. FOX, D.Sc. (LOND.)

*South African Institute for Medical Research*

The spontaneous energies of the earth are a gift of nature, but they require the labour of man to direct their operation. And the question is so to husband this labour as to turn the greatest quantity of this useful action of the earth to his benefit.

*Thomas Jefferson, 1813*

Even when climatic and other natural conditions are favourable food can only be produced when man applies effort and skill to the land; thus the quantity depends on the amount of land farmed, the number and skill of those engaged in the task, together with the availability of various other necessities, including capital, tools, labour, etc. Discussing such aspects very briefly we shall confine our attention to the European farmer, since at present the major contribution of the non-European is made in his role as a farm labourer.

**Area of Farm Land.** About 70% of the Union is farmed by Europeans and about 12% by non-Europeans (though the latter occupy about 24% of the land with a rainfall of 20 inches and

over). The remainder consists of game reserves, municipal areas, mines, roads and railways. In the Orange Free State over 90% of the land is farmed by Europeans, whereas in Natal the percentage is less than 50.

**Size of Farms.** The area under farms and holdings has increased by only about 5% since 1930 and most of this gain was before 1937. But the number of farms increased from 97,000 in 1930 to 119,000 in 1952; that is to say, the average size of farms decreased from about 1,000 to 850 morgen (Table I). The increase in numbers has been mostly among the smaller-sized farms. More recently farms in some categories have tended to increase in size. Size of farm is of importance in relation to productivity, which can generally be increased with decreasing size. However, a unit may be of sub-economic size, which raises difficulties that in the past have led to most unfortunate results, both to the farmer and his land. In other words size must be related to local conditions and to the farmer's skill.

**Number of Food Producers.** Assuming that all farmers produce edible products for sale, we find that, over the years, not only

TABLE I.—AREA, NUMBER AND AVERAGE SIZE OF EUROPEAN FARMS. PERSONS DEPENDENT ON THEM FOR FOOD

European Farms and Holdings			Population dependent on European Farms for Food			
Area (Morgen)	Number	Average Size* (Morgen)	Europeans (Total Population) Millions	Non-Europeans (Urban Population) Millions	Total† Millions	Average Number of Persons fed per Farm‡
1921 ..	—	86,441	1.52	0.89	2.41	28
1930 ..	96,674,000	96,940	1.83	(1.3)	3.10	32
1937 ..	99,911,744	104,554	2.00	1.70	3.70	35
1947 ..	101,564,000	113,990	2.37	2.43	4.80	42
1952 ..	101,870,528	119,556	2.64	3.00	5.64	47

\* Data from Population and Agricultural Censuses.

† Should be increased by non-Europeans living on European farms—approximately 2 million in 1952.

‡ Arithmetical mean; merely to indicate trend.

TABLE II.—OUR CHANGING FARM POPULATION\*

	Europeans (Adult Males)	European Labourers (Males)	Total Farm Bantu Population	Total non-European Labour Force	Male Bantu Labour Force (excluding Domestic Servants)
1930 ..	149,363	—	—	475,909	361,269
1937 ..	155,725	—	2,181,803	764,149	464,000†
1946 ..	159,302	14,587	2,222,555	711,483	473,000†
1950 ..	126,331	13,824	2,214,047	867,359	522,000†
1952 ..	—	10,549	—	918,187	567,000†

\* Data from Population and Agricultural Censuses and Bureau of Economics and Markets.

† Estimated.

In 1949-50 the total European population on farms was 472,952.

has there been a marked decrease in the *proportion* of the total male population over 16 who engage in farming, but there has also been a decrease in the *actual number* thus engaged, in spite of the fact that the number of farms has increased considerably (Table II). It is not easy to estimate how far this decrease is due to particular causes, such as the attractions of urban life, the disappearance of the poor and inefficient 'subsistence' farmer, changes in farming systems, or the increasing amount of capital required by modern farming. But as long as there are young and suitable men who want to farm, yet for one reason or another cannot do so, the situation cannot be viewed with complacency from the point of view of the food needs of the future.

**Farmer Stability.** That the stability of the present-day farmer has improved is shown by the steady increase in the proportion of owner-farmers (now about 70%) and the decrease of tenants, share-croppers and *bywoners*. This change is of no small importance both for the farmer and the land he works, and thus bears directly on our food-production prospects.

**Farm-Labour.** Since the number of adult European males engaged in farming is only slightly greater than the number of farms it is obvious that the number and the skill of those assisting him (almost entirely non-Europeans) is of the greatest importance (Table II). The number of Natives employed per farm has never been so high as it is today, yet the need for more labour has never

been so frequently publicized. This issue requires more study, particularly with a view to overcoming the present high turnover and the general low efficiency of non-European labour. Labour is said to account for 25% of the cost of producing maize, wheat and milk, and 50% of that of sugar.

**Knowledge and Skill.** Some 3,000 farmers enter the profession each year. Not so long ago many of these were coming straight from school, sometimes not even having passed standard VI. Today, not only is the general scholastic level rising steadily, but, as the complexity of modern farming is becoming better appreciated, the demand for more specialized training is increasing. Formerly the 5 agricultural colleges were but poorly attended; now, with extended facilities accommodating 340 students, there is a long waiting-list and the need for more accommodation is frequently stressed by farmer-organizations. Better roads, improved methods of transport, more technical reading matter, films and the radio have also done much to widen horizons and keep the farmer more up-to-date. The development of farmer organizations, including a flourishing co-operative movement has also played an important part.

**Research and Technical Services.** It is true that the average farmer does not make full use of existing knowledge that would be of great assistance to him. Unfortunately it is also true that

TABLE III.—MECHANIZATION OF FARM OPERATIONS\* (FIGURES IN THOUSANDS)

	1926	1937	1946	1950
<b>A.—Increased use of machinery.</b>				
Ploughs, all types .. .. .	212.0	251.3	264.5	256.2
Harrows, all types .. .. .	80.0	133.8	153.6	166.1
Planters .. .. .	43.6	57.8	74.1	81.0
Mowing machines .. .. .	23.5	32.7	40.0	43.0
Lorries and trucks (motor) .. .. .	—	8.6	21.3	31.3
Lorries and trucks (other) .. .. .	84.9	99.3	102.9	72.1
Motor cars .. .. .	—	52.0	56.6	63.6
Tractors, all types .. .. .	1.3	6.0	22.3	48.4
				1952 approx. 60
				1954 approx. 80
<b>B.—Decreased use of animals:</b>				
Horses .. .. .	685.3†	404.5	346.6	303.0
Mules .. .. .	124.1†	122.7	100.3	92.7
Donkeys .. .. .	622.2†	497.5	375.1	319.8
Trek oxen (no figures available)				

\* Data from Agricultural Censuses.

† Includes those owned by non-Europeans living on European farms.

South Africa teems with indigenous farming problems that await solution. The necessary research work is slow and yet must anticipate the needs of the future. At present the excellent work done by a handful of men is woefully inadequate to meet these needs. The shortage of agronomists, plant breeders, entomologists, to mention but a few, as well as soil conservationists, animal husbandrymen, veterinarians and extension officers hampers production in many ways and also gives rise indirectly to enormous losses both of crops and livestock; it is the subject of much anxious thought which is leading to some promising developments.

**Machinery.** In Table III figures are given to illustrate another change taking place on our farms, i.e. the steady growth of mechanization. Outstanding is the increase in the use of tractors, which enable a variety of tasks to be undertaken and completed more quickly while weather conditions are favourable; more land can be cultivated, weeded, etc. and hence the farm made more productive; ultimately labour requirements should be reduced. Tractors enable more, not less, animals to be kept on the farm, though of a different type. However the design and choice of machinery really suited to local physical and economic conditions poses many problems which are beginning to receive more attention. The complete dependence upon imported fuel must not be overlooked.

**Fencing.** Fencing may be taken as another example of the 'mechanics' of food production. In 1943, Meredith<sup>1</sup> estimated that 'European farms in the Union alone require at least an additional 300,000 miles of fencing in order to secure some degree of control over grazing'. During 1952 alone farmers spent over £4 million on fencing, almost a quarter of which was required for repairs.

**Fertilizers.** Food production on the scale required for the future will depend on the availability of immense quantities of fertilizers, using the term in its widest sense, though with particular emphasis on phosphorus and nitrogen. Production within the Union is steadily improving, but, if recent discoveries regarding the value of nitrogen on grazing lands are to be implemented on a large scale the amounts required will be gigantic. It must not be forgotten that such supplies must be shared with the demands of industry, which are increasing just as rapidly.

Adequate supplies of fertilizers and fencing at reasonable prices have been described as possibly the two main necessities for a substantial increase of food in the future.

**Rural Electrification.** Reporting in 1945 on *The Future of Farming the Social and Economic Planning Council*<sup>2</sup> drew attention to the progress being made with rural electrification in other countries, including Russia. 'One reason for the efficiency of

New Zealand dairying is the extensive rural electrification. . . . The Union is most backward in this respect and it is a development which the Council believes to be urgent and essential'. Nine years have passed and the Union is now even more backward by comparison, though an Act passed in 1947 holds greater promise for the future. The Electricity Supply Commission now supplies 3.7% of our farms, though only half use electricity for farm operations. In Australia 31%, in England 40%, in Tasmania 74% and in the U.S.A. 90% of the farms are served by electricity. Our large and sparsely populated areas create real economic difficulties, but presumably this applies equally to Australia, which is 7 times the size of the Union. Electrification not only improves the efficiency of some types of farming, but, by improving the amenities of rural life it helps to keep the younger people on the land, where they are so badly needed.

**Agricultural Credit.** Formerly farming did not require a great deal of capital, but the position is very different to-day. Table IV shows the rising cost of land, but the cost of equipping and maintaining a modern farm for efficient production has also greatly increased. The progressive farmer can usually acquire the capital for obtaining land; he has real difficulty, according to some authorities, in obtaining it for productive purposes.

TABLE IV.—RISE IN AVERAGE COST OF LAND IN RURAL AREAS ONLY DURING LAST 10 YEARS

		Total Area of Land Changing Hands (million morgen)	Average Price per Morgen
1942/3	.. .. .	8.8	£2 12 0
1943/4	.. .. .	9.2	£3 7 0
1947/8	.. .. .	8.0	£6 5 0
1951/2	.. .. .	7.0	£6 16 0
1952/3	.. .. .	5.9	£8 0 0

**Conclusion.** Even this superficial survey shows that farming in South Africa is passing through some profound economic, technological and social changes. Since the national health depends ultimately upon a stable and prosperous agriculture it is essential that the various needs arising from this period of transition should be adequately met.

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2. Soc. and Econ. Plan. Council. Rep. No. 4, 1945.

### GENERAL PRACTICE IN ENGLAND\*

Three years ago the Nuffield Provincial Hospitals Trust invited Dr. Stephen Taylor to conduct a non-statistical survey of a number of outstanding general practices, to see how far lessons they had to teach could be generally applied. The report of the survey was published in March 1954 by the Oxford University Press for the Nuffield Provincial Hospitals Trust, under the title *Good General Practice* (604 pp., price 12s. 6d.).

The survey has covered the work of 94 doctors in 30 practices distributed throughout England and Wales. Of the practices, 15 were in industrial areas, 6 in urban-residential areas and 9 were in the countryside or in small country towns.<sup>1</sup>

It emerged early in the survey that the type of practice depends largely on the environment in which it is set. Nearly a third of the people of England and Wales live in the so-called industrial areas, composed of the crowded and often dilapidated homes of the factory population. Although there are many doctors who are of high calibre in such places, the general level of practice organization is lower than elsewhere. Nevertheless, it is starting to improve. Practice from lock-up shops is common, and most of the doctors live away from their places of practice. Equipment is often

inadequate, and secretarial or other help is the exception rather than the rule.<sup>2</sup>

#### ROTA SYSTEMS

An encouraging change in the industrial areas is the development of *rota systems*. Since the start of the National Health Service, financial competition among industrial GPs has been much less acute. As a result, co-operative mutual-help schemes have started in many places. Six or seven GPs have come together and worked out arrangements so that at nights and week-ends one or two go on duty for the patients of all. As a result, the patients receive a better emergency service and the doctors are no longer worn out by continuous duty.<sup>3</sup>

Some doctors object to the idea of a rota system, on the grounds that their patients are opposed to it. To test this a special study of the views of the public was made in the Borough of Ilford. Here 65 out of the 66 doctors operate rota systems. With the co-operation of the Ilford doctors, samples of the general public and of known rota-users were interviewed to find out what they thought of the arrangement. Over 85% favoured the rota scheme, and the few critics were mainly concerned with minor difficulties which have arisen in the details of its operation.<sup>4</sup>

It is in the industrial areas that improvement of the physical environment of the doctors is most needed. It is here, too, that they can themselves do most to improve their conditions of work by re-arranging their surgery premises and employing adequate ancillary help. In industrial areas where the local-authority clinic

\* A summary of the book *Good General Practice* issued by the Nuffield Provincial Hospitals Trust, Nuffield Lodge, Regent's Park, London, N.W.1.



buildings are unsatisfactory, the case for building health centres is a strong one. But where there are good clinic buildings, it would be wasteful in the extreme to replace them by health centres.

The most satisfactory solution is for the GPs to start group practices in new or converted buildings. Several group practices might be linked with a single large clinic, and it is hoped that the GPs may work at the local-authority clinics, while the district nurse, midwives and health visitors, in their turn, work at the GPs' group-practice buildings.

Rota schemes may provide a stage in the development of group practice in industrial areas, and experiments on these lines should be encouraged. A rota is evidence of the will to co-operate.<sup>8</sup>

On the whole, *urban-residential practice* is usually of a high standard. But the outstanding examples of practice, from the point of view of organization, are to be found in the *small country towns*. Here group practice is the rule, and the doctors have generally created a well-equipped practice-house in the centre of the town. There will be an adequate staff of secretaries, good waiting-rooms, consulting-rooms and offices, often a dispenser, and sometimes a small operating theatre for minor surgery, and a small laboratory.<sup>9</sup>

A careful study was made of *group practice* as compared with single-handed practice and the small partnership. On the basis of the practices visited a set of criteria of group practice have been laid down.<sup>7</sup>

The advantages and disadvantages of group practice have been carefully examined, and the conditions for successful group practice are set out. Possible sources of friction are looked at, especially the way the practice income is divided, the way the work is divided, and the influence of wives on the group.<sup>8</sup>

Some remarkable facts about the *volume and pattern of work* of the GP have emerged. It appears that on an average a doctor performs about 5 acts of service (whether in the patient's home or in the surgery) for each patient on his panel list in the course of a year. This figure includes a number of patients who make no calls at all on the doctor's time. These are offset by a number who will make 10 or more calls in the course of a year.

The amount of work different doctors do varies greatly. In the survey the range was from an average of 24 'items of service' a day, up to an average of 87 items a day. Naturally, the bigger the list, as a rule the greater the number of items of service. But this was only part of the story. An analysis was made of the average number of services rendered per patient at risk in the course of a year. It was found that the range was from 3.5 services a year up to 8.7 services a year. This means that one doctor may be rendering nearly 2½ times as many services for each of his patients as another, though both are paid the same capitation fee.

This striking difference was found to be due almost entirely to the varying amounts of ill-health in different parts of the country. Thus the infant mortality rate in the area surveyed varied from 16 deaths of children under one year of age per 1,000 children born, up to 57. The areas of greatest ill-health were South Wales, Lancashire, Durham and Northumberland, and industrial Yorkshire. The most healthy area was South-east England, especially the suburban areas around the great cities, and the small country towns.

On the basis of the point at which fatigue seemed to start, it was calculated that the optimal maximum list of a GP ought to be between 2,500 and 3,000 patients (the legal maximum is now 3,500).<sup>9</sup>

#### PAPER WORK

There have been many complaints about the amount of *paper work* which doctors are expected to do nowadays. The picture painted is of the GP snowed under by a deluge of certificates for corsets, coal, and other not obviously medical items. But in the practices surveyed there were no serious complaints of excessive paper work. Every doctor is occasionally irritated by an exceptional situation, but continuous frustration at the amount of written work usually means that there has been failure to organize the clerical side of a practice.

The report discusses in detail the best way for a GP to keep his medical records and deal with certificates. Well-kept records are the greatest single help in maintaining a high standard of practice. On the whole, the NHS record-cards, certificates, and other forms, are well-adapted for their purpose, though some of the documents coming to the GPs from hospitals could be improved.<sup>10</sup>

*Waiting at the doctor's surgery* has become an accepted part of the British way of life. The queues at the 'bus stop are mirrored in the queues inside the surgery, and sometimes outside as well. Efforts by doctors to persuade their patients to spread out their

times of arrival have no effect; some like to turn up half an hour before the start of the surgery, while others pin their faith on arriving at the last minute before the door closes. As a result, every year millions of working hours are wasted in doctors' waiting-rooms throughout the country.

The answer is a proper *appointments system*, and successful appointments systems in general practice are described in the report. Not only do they save patients' waiting time, but they reduce the chances of cross-infection. But it may take months to teach patients to use an appointments system, and there are some people who could never be taught to use it. Moreover, the doctor must have someone continuously on duty to book appointments.<sup>11</sup>

The range of *accommodation* which doctors provide for themselves and their patients is astonishing. Some surgeries are ill-lit, ill-ventilated, and ill-equipped, while others are carefully planned and meet fully the needs of both patients and doctors. The importance of accommodation must not be over-emphasized. It is better to have a good doctor practising from bad accommodation than a bad doctor in the best possible accommodation. Yet even the best doctors suffer from unnecessary fatigue in a bad working environment.

As a result of the survey it is suggested that the basic unit of accommodation for a GP should in future be a minimum of 3 rooms—waiting-room, consulting-room, and examination-room—rather than waiting-room and consulting-room only.

An examination-room makes it possible for one patient to be undressing while another is being interviewed. Not only does this save time, but because it avoids a hold-up in the flow of his surgery work, it encourages the doctor to examine his patients when this is necessary.

If the GPs concerned are to improve their standards of accommodation, they must be shown what is needed and what can be achieved under existing circumstances by adapting even apparently unsuitable buildings. A number of examples of successful adaptation are given in the report. Improvements in accommodation cost money and give no direct cash return. The benefit which they bring is rather in terms of work made easier and more efficient.<sup>12</sup>

A careful analysis of the doctors' *bags and equipment* has been made. What the GP has in his surgery or carries with him depends partly on the hospitals and specialists available to him, and partly on his own assessment of his skill and obligations. The GP must not attempt what is really beyond him; at the same time he must not pass on work to the hospitals which he can himself safely undertake.<sup>13</sup>

*Ancillary help*, secretarial or nursing, is one of the hallmarks of the good GP, though there are some excellent GPs who are able to manage without it. In only one of the 30 outstanding practices visited was no such help employed. By contrast, among practices as a whole, half have no ancillary help. Any doctor with more than about 2,500 patients on his list probably needs such help. As a rule, a doctor can make careful use of a secretary in his surgery, rather than a nurse, though it is a definite advantage if a nurse, and particularly the district nurse, can be available at the surgery for injections and dressings.<sup>14</sup>

GPs are agreed that one of their outstanding needs, particularly in the large industrial towns (including London), is for them to be able to refer their patients *direct* to hospital *pathological laboratories* and *X-ray departments*, without the patients having first to see hospital specialists in out-patient departments. Where such a service is available, there is no evidence of abuse by the GPs and it even saves the hospitals some work, by reducing the number of out-patient consultations which are needed.<sup>15</sup>

#### HOSPITAL POSTS

Less than half the GPs visited on the survey held *hospital posts*. For most GPs there appeared to be special value in the type of post known as 'clinical assistant'. Such a post gives a GP a fresh insight into hospital work and acts as a powerful stimulus and a help in keeping up-to-date. It should normally be held for a period of 6 months, and every GP should have a chance to be a clinical assistant from time to time. Some GPs will continue to work in a particular department of a hospital over the years and will in due course acquire full specialist skills.<sup>16</sup>

It is important that new links should be built between the *preventive health services run by the local authorities* and the general practitioners. Relations between the GPs and the district or home nurses and the midwives are excellent. But there is still a gap to be bridged if GPs and health visitors are to be brought together.





Heinrich Wilhelm Ferdinand Wackenroder 1798 - 1854

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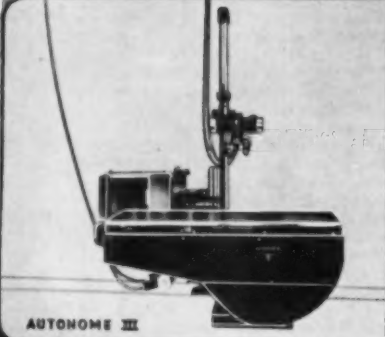
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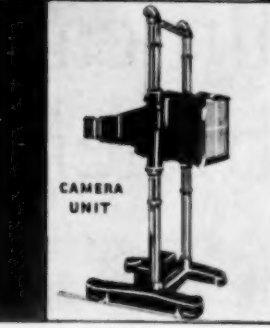
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On an average, there is 1 district nurse to every 7,000 of the population and 1 to every 3 GPs. But there are wide local variations. In the towns visited on the survey the range was from 1 district nurse to every 7,000 people up to 1 to every 26,000 people. In the countryside there is usually 1 district nurse to every 3,000-4,000 people. If there were many more district nurses they could make a substantial contribution towards saving hospital beds, especially for the chronic sick. In the industrial areas 1 district nurse for every 4,000 people might well be needed if the best results are to be obtained.

The local-authority clinics for maternity and child-welfare should be increasingly staffed by GPs. Where this has already been done the benefits to patients and staff are substantial, and the difficulties so often predicted by the theorists do not seem to have arisen.<sup>17</sup>

In the course of the survey, it became apparent that there is a group of people who appear to get ill more often than the rest of the community. They are more *sickness-prone* than their fellows, and in addition they have a *lower threshold of complaint*. With troubles which most of us would grin and bear, assisted by some aspirin or whisky, they seem compelled to visit the doctor.

It seems that this group makes up about 15% of a doctor's patients; they are responsible for about 50% of his work. The group does not include the ordinary seriously ill patients whose

requirements for extra help are usually concentrated into a comparatively short period. These multiple-ailment heavy-burden patients constitute the GPs biggest single problem. At any time they may develop serious disease, so their apparently trivial complaints must never be dismissed out of hand. The best way of dealing with them appears to be regular thorough physical examination. This enables reassurance to be given against a sound medical background, while the knowledge that examination is certain to follow complaint acts as a mild deterrent against frivolous groaning.<sup>18</sup>

## REFERENCES

In the following list the first figures represent pages in the text of the book and the second figures pages in the summary.

- |                           |                                       |
|---------------------------|---------------------------------------|
| 1. pp. 12-17, 448-450.    | 11. pp. 184-189, 498-499.             |
| 2. pp. 33-41, 453-454.    | 12. pp. 202-225, 501-509.             |
| 3. pp. 123-145, 483-489.  | 13. pp. 251-285 and 586-591, 509-513. |
| 4. pp. 138-145, 556-575.  | 14. pp. 286-305, 513-517.             |
| 5. pp. 116-122, 479-483.  | 15. pp. 327-331, 519-521.             |
| 6. pp. 41-49, 454-458.    | 16. pp. 332-363, 521-530.             |
| 7. pp. 94-95, 471-472.    | 17. pp. 364-392, 530-538.             |
| 8. pp. 98-115, 472-478.   | 18. pp. 420-423, 541-542.             |
| 9. pp. 57-89, 459-470.    |                                       |
| 10. pp. 146-175, 489-496. |                                       |

## SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL : ETHICAL RULES

The Minister of Health has (in Government Notice No. 571 of 1954) approved of the amendment of the rules regarding conduct of which the Council may take cognizance,\* as follows:

In Rule 1:

- (a) by the substitution in paragraph (3) of the word 'an' for the words 'a sealed'.

Paragraph 3 as thus amended reads: 'Issuing . . . cards, handbills or pamphlets . . . except to bona fide patients, intimating change of address, dissolution of partnership and the like, in which case the communications themselves must bear the name of the patient to whom they are addressed and must be enclosed in an envelope'.

- (b) by the deletion in paragraph (5) of the words 'name without any qualification and a'.

Paragraph 5 as thus amended reads: 'The printing on envelopes of any information other than the practitioner's return address in case of non-delivery'.

- (c) by the substitution in General Note (i) of the word 'an' for the words 'a sealed'.

General Note (i) as thus amended reads: 'A medical practitioner or dentist in general practice may send notifications of having commenced practice to other medical practitioners or dentists, in which case the communications themselves must bear the name of the practitioner to whom they are addressed and must be enclosed in an envelope'.

- (d) by the substitution in General Note (ii) of the word 'an' for the words 'a sealed'.

General Note (ii) as thus amended reads: 'A medical practitioner or dentist who has been registered as a specialist may send notifications

to other medical practitioners or dentists of having commenced practice in his speciality, in which case the communications may contain only his name, address, qualifications and his speciality, and the communications themselves must bear the name of the practitioner to whom they are addressed and must be enclosed in an envelope'.

By the insertion of the following new rule:

19 bis: *Appointments to Universities and Research Institutions*—(1) Acceptance by a medical practitioner or a dentist of any professional appointment to a university or research institute, unless:

- (a) notice inviting applications for such appointment shall have been advertised in the Official Journal of the Medical or Dental Association of South Africa (as the case may be);
  - (b) details of the proposed appointment are made available to bona fide enquirers, and to the Council on request;
  - (c) The contract is in writing and sets out clearly the clinical or professional services which the medical practitioner or dentist agrees to render and the fees or remuneration which shall be payable to him by the party appointing him, for such services.
- (2) Failure by any medical practitioner or dentist who has accepted an appointment under this rule to submit for inspection by the Council the contract referred to in this rule within 30 days from the date of posting of a demand therefor in a registered letter from the Registrar of the Council addressed to such medical practitioner or dentist at his address as shown in the register; provided that upon good cause shown by such medical practitioner or dentist this period of notice may, in the discretion of the Council, be extended.

\* See this Journal 27, 332 (18 April 1953) and 27, 860 (26 September 1953).

## ASSOCIATION NEWS : VERENIGINGSNUUS

At the Annual General Meeting of the South West Africa Branch of the Association held on 9 April 1954 the election of office bearers for the ensuing year was as follows:

President—Dr. F. J. Marais; Vice-President—Dr. C. W. L. Crawford; Honorary Secretary/Treasurer—Dr. H. C. Paradis-

garten; Branch Council members—Dr. G. H. Maul; representing the Northern Territory—Dr. H. P. Kirsten (Usakos); representing the Southern Territory—Dr. J. Gildenhuys (Mariental); Representative of the Branch on the Windhoek Hospital Board—Dr. G. D. van Schalkwyk; Representative of the Branch on the Cripple Care Association—Dr. C. F. G. Fourie.

## PASSING EVENTS : IN DIE VERBYGAAN

S.A. MEDIESE KONGRES, 21-26 JUNIE 1954, PORT ELIZABETH

Die aandag van lede word daarop gevestig dat, indien hulle van plan is om die Suid-Afrikaanse Mediese Kongres by te woon wat van 21 tot 26 Junie 1954 te Port Elizabeth gehou sal word,

hulle die intensiekaartjies, wat onlangs aan hulle gestuur was, so gou moontlik moet voltooi en aan die Organiserende Sekretaris, Suid-Afrikaanse Mediese Kongres 1954, Posbus 1137, Port Elizabeth, terugstuur.

## UNION DEPARTMENT OF HEALTH BULLETIN

Report for the seven days ended 8 April 1954

Plague. Smallpox. Typhus Fever. Nil.  
 Epidemic Diseases in other Countries  
 Plague. Nil.  
 Cholera in Chalna, Chittagong, Dacca (Pakistan); Calcutta (India).  
 Smallpox in Mogadiscio (Somalia); Basra (Iraq); Dacca, Karachi (Pakistan); Bombay, Calcutta, Cochin, Delhi, Kanpur,

Madras, Nagapattinam (India); Bassein (Burma); Haiphong, Hanoi, Saigon-Cholon (Viet-Nam); Inchon, Pusan (Korea).  
 Typhus Fever in Baghdad (Iraq).

## CAPE TOWN PAEDIATRIC GROUP

A meeting of this Group will be held in the E Floor Lecture Room at the Groote Schuur Hospital, Observatory, Cape, at 8.15 p.m. on Friday, 7 May 1954, when cases will be shown and discussed.

## REVIEWS OF BOOKS : BOEKRESENSIES

## CLINICAL PSYCHIATRY

*Modern Clinical Psychiatry.* By Arthur P. Noyes, M.D. (Pp. 609 + viii. Fourth edition. £2 19s. 6d.) Philadelphia and London: W. B. Saunders Company, 1953.

*Contents:* 1. Psychiatry and the 'Mind'. 2. Development of Dynamic Psychiatry. 3. Personality Development and Structure. 4. Mental Mechanisms and Their Functions. 5. The Causes and Nature of Mental Disorders. 6. Symptoms of Mental Disorder. 7. Examination of the Patient. 8. Disorders Caused by or Associated with Impairment of Brain Tissue Function: Intracranial Infection. 9. Brain Syndromes Due to Drug or Poison Intoxication. 10. Alcoholism and Alcohol Psychoses. 11. Mental Disorders Due to or Associated with Head Trauma. 12. Brain Syndromes Associated with Circulatory Disturbances. 13. Acute Brain Syndromes Associated with Metabolic Disturbances. 14. Chronic Brain Disorders: Syphilitic Meningoencephalitis. 15. Mental Disturbances with Other Forms of Syphilis of the Central Nervous System. 16. Brain Syndromes Associated with Cerebral Arteriosclerosis. 17. Brain Syndromes Associated with Convulsive Disorders (Epilepsy). 18. Senile Psychoses. 19. Chronic Brain Syndromes Associated with Disturbance of Metabolism. Growth or Nutrition. 20. Chronic Brain Syndrome Associated with Intracranial Neoplasm. 21. Chronic Brain Syndrome Associated with Diseases of Unknown or Uncertain Cause. 22. Mental Deficiency. 23. Disorders of Psychogenic Origin. 24. Psychotic Disorders: Involutional Psychotic Reactions. 25. Psychotic Disorders: Affective Reactions. 26. Psychotic Disorders: Psychotic Depressive Reaction. 27. Psychotic Disorders: Schizophrenic Reactions. 28. Psychotic Disorders: Paranoid Reactions. 29. Psychophysiologic Autonomic and Visceral Disorders. 30. Psychoneurotic Disorders. 31. Personality Disorders. 32. Sociopathic Personality Disturbances. 33. Drug Addiction. 34. Child Psychiatry. 35. Shock and Other Physical Therapies. 36. Psychotherapy. Index.

With a knowledge of the previous editions of this book, it was expected that this 4th edition would adequately cover the rapid advances in psychiatric science during the last 5 years, and at once it is possible to say then, that objective has been achieved in no uncertain manner.

Dr. Noyes has a happy knack of presenting his material in flowing English, very easily read and yet covering his subject with a conciseness and clarity which will prove to be a delight to those who have to keep themselves abreast of the times not only in psychiatry but in a multitude of other medical subjects, namely the general practitioners. At the end of each chapter the author presents an extensive bibliography for the guidance of those whose work requires a more detailed study of the subject.

In the preface to this edition, Dr. Noyes emphasizes that he has tried to present more fully the principles of basic psychiatry and also that greater emphasis has been placed on psychological influences and motivations in the production of personality disorders. Certainly he has fulfilled these promises. He further adds that the classification of mental disorders has been completely changed in this edition, and that he has adopted the classification approved by the American Psychiatric Association, believing as he does that it is in accordance with present concepts concerning personality disturbance. In reading the chapter on *Examination of the Patients and Classification of Mental Disorders*, it becomes clear that Dr. Noyes is no ardent advocate of any particular classification of mental disorders, other than for statistical purposes and possibly for use in 'eliminating those considerations least likely to be useful in understanding the patient and in directive attention to those which are likely to be relevant'. It is indeed refreshing to find it the underlying theme in all his statements that the important thing is an understanding of the patient himself and not the labelling of his psychosis.

It is impossible within the limits permitted to deal with all the excellent chapters in this outstanding book, but it can be said that each one gives a carefully balanced presentation of its subject.

Outstanding perhaps is the chapter on *The Causes and Nature of Mental Disorders*. It is an extremely difficult and contentious subject and yet within the space of about 30 pages the reader is given a clear account of the position as it is today. The author has expressed his views and those of others in plain language and eliminated the necessity for frequent reference to a medical dictionary to elucidate the difficult terminology commonly seen in current psychiatric literature. To the general practitioner, meeting as he does mental illness in its earliest stages, this chapter will be of great value.

Of undoubted interest to both the practitioner and the psychiatrist is the subject of psychosomatic medicine, and in this book the chapter headed *Psychophysiologic Autonomic and Visceral Disorder*, completed as it is by an extensive bibliography, opens up in an admirable manner a vast field of common interest to all members of the medical profession.

Current psychiatric opinion, particularly in the medico-legal field, presents many and varied views concerning the 'psychopath' not only in regard to treatment but also in relation to criminal responsibility. In discussing *Sociopathic Personality Disturbances*, Dr. Noyes presents a point of view which admits the limitations of psychiatric methods, and also accepts the difficulties of the legal profession in finding a common meeting ground for this problem. Very wisely he makes no special claim for the psychiatric approach. Unfortunately he does not give his views on the desirability of the establishment of special institutions for the care, supervision and control of a world-wide social menace, namely the delinquent psychopath.

This is a book which can be confidently recommended as one which should have a place on the bookshelves not only of the practising psychiatrist but also of the medical practitioner and the medical student.

G. J. K.

## PATHOLOGY

*Pathology.* Edited by W. A. D. Anderson, M.A., M.D., F.A.C.P. Second Edition. (Pp. 1393 + xv, with 1241 illustrations and 10 colour plates. £6 16s. 0d.) St. Louis: The C. V. Mosby Company, 1953.

*Contents:* 1. Introduction. 2. Cells and Their Behavior. 3. Inflammation. 4. Degenerative Changes and Disturbances of Metabolism. 5. Disturbances of Circulation. 6. Physical Agents in the Causation of Injury and Disease. 7. Chemical Injury. 8. Effects of Radiation. 9. General Principles of Infection and Resistance. 10. Bacterial Diseases. 11. Tuberculosis. 12. Leprosy. 13. Spirochetal and Venereal Diseases. 14. Rickettsial and Viral Diseases. 15. Fungal Infections. 16. Protozoal and Helminthic Infections. 17. Vitamins and Deficiency Diseases. 18. Neoplasms. 19. The Heart. 20. The Blood and Lymphatic Vessels. 21. The Kidneys. 22. The Lower Urinary Tract and Male Genitalia. 23. The Lung. 24. The Organs of Special Senses. 25. The Lips, Mouth, Teeth and Neck. 26. The Gastrointestinal Tract. 27. The Liver. 28. The Gall Bladder and the Biliary Ducts. 29. The Pancreas. 30. Diabetes Mellitus. 31. The Blood and Bone Marrow. 32. The Spleen, Lymph Nodes, and Reticulo-Endothelial System. 33. The Thymus. 34. The Pituitary Gland. 35. The Pineal. 36. The Thyroid. 37. The Parathyroids. 38. The Adrenal Glands. 39. The Female Genitalia. 40. The Breast. 41. The Skin. 42. The Bones. 43. The Joints. 44. The Nervous System. 45. Heredity and Constitution in Disease. Index.

Anderson's *Pathology* appeared first in 1948, a large volume of 1,426 pages, in the preparation of which no fewer than 28 professors of pathology and 5 other distinguished anatomists or pathologists had collaborated. The 1st edition was reprinted 3 times, and now the 2nd edition has appeared.

The new edition resembles the first in its general presentation of the subject. Most of the original authors are represented, but in



addition, T. Winship appears as co-author in the chapter on the Thyroid, and J. A. Saxton in the chapter on the Adrenal. The number of pages has dropped to 1,349, in spite of the addition of much new material, and a new and instructive colour-plate has been added of the spread of infection within the head along venous channels. The new volume is as well and as profusely illustrated as the first.

Anderson's *Pathology* is encyclopaedic in its scope, as a glance at the contents will show. All the authors are experts in their fields and men of standing in medical science in the United States. The quality of its contents, as may be expected, is high and the style concise. Each chapter is followed by a list of recent references—a feature which adds to its value.

This book will meet the demands of students of pathology, both undergraduate and post-graduate, in a most satisfactory way. To the practising pathologist, it is a very useful tool of reference, and I can thoroughly recommend it as a source of accurate and relatively detailed pathological information to my clinical colleagues.

B.J.P.B.

## A COMPENDIUM OF PAEDIATRICS

*Paediatrics. Volume I.* By miscellaneous contributors, under the general editorship of Wilfrid Gaisford, M.D., M.Sc., F.R.C.P. and Reginald Lightwood, M.D., F.R.C.P., D.P.H. (Pp. 1-563 + xv with 102 figures. £4 1s. 6d.) London: Butterworth & Co. (Publishers), Ltd., 1953: South African Office: Butterworth & Co. (Africa), Ltd., Durban.

*Contents:* Preface. Introduction. *Part I. The Child in Health.* 1. The Normal Child in Health. 2. Normal Physical Development. 3. Normal Mental, Emotional and Social Development. 4. Management of the Normal Child. *Part II. The Newborn Baby.* 5. Antenatal Paediatrics. 6. Stillbirths and Neonatal Deaths. 7. Prematurity. 8. Care of the Newborn Baby—Full Term and Premature. 9. Congenital Abnormalities. 10. Trauma in the Newborn. 11. Disorders of the Newborn. 12. Infections in the Newborn. *Part III. The Infant.* 13. The Principles Underlying Infant Feeding. 14. Breast Feeding. 15. Artificial Feeding. 16. Weaning and Mixed Feeding. *Part IV. Preventive Paediatrics.* 17. Morbidity and Mortality Statistics. 18. Heredity. 19. Immunization and Prophylactic Inoculations. 20. The Child in Hospital: The Aspect Important to the Family Doctor. 21. Public Health. 22. The Law and the Child. *Part V. Diagnosis.* 23. Clinical Examination. 24. Common Signs and Symptoms. 25. Abnormality of Stools. *Part VI. General.* 26. General Nursing of the Child Ill at Home. 27. Anaesthesia. 28. Blood Transfusion and Parenteral Fluid Administration. 29. Simple Procedures and Special Examinations. 30. Physical Therapy. 31. Chemotherapy. 32. Drugs in Childhood. 33. Poisoning. 34. Shock and Burns. 35. Unexpected Sudden Death During Infancy. *Part VII. Nutrition and Malnutrition.* 36. Nutrition. 37. Malnutrition and Marasmus. 38. Dehydration and Disturbance of Acid-Base Balance. 39. Vitamin Deficiency Diseases. 40. Oedema and Malnutrition. *Part VIII. Cardiovascular System.* 41. General Observations on Normal Findings. 42. Rheumatism and Rheumatic Carditis. 43. Congenital Heart Disease. 44. Bacterial Endocarditis. *Part IX. The Blood.* 45. Blood in Infancy and Childhood. 46. Anaemias of Infancy and Childhood. 47. Bleeding Diseases. 48. Leukaemia and Hodgkin's Disease. *Part X. Tumours in Childhood.* 49. The Present Status of the Treatment of Malignant Tumours in Childhood. Index.

Those who study the catalogues of booksellers—and the medical fraternity are addicted to the practice—may be inclined to groan on seeing yet another symposium on paediatrics at a still higher price than other modern works of reference in this field. This one is addressed to the general practitioner and, judged by Volume One, will repay the not-inconsiderable financial outlay by supplying him with the basic information which he requires while, at the same time, giving at the end of each chapter a short list of references to modern publications to which recourse may be had for more detail.

The authors vary in origin from Canada to Cape Town (the section on Malnutrition and Oedema is contributed by Dr. W. Emdin). They have adapted their material to give the sort of information that a busy general practitioner wants to find quickly and from which he may obtain practical help. References to purely experimental work are minimal and the text is related to the clinical aspect without pathological descriptions or other digressions. Yet the different writers have succeeded in giving a mass of easily read information without even approaching a mere catalogue of signs, symptoms and treatment. The illustrations and diagrams are clear, and, on the whole, well produced. The index is admirable. The print is sufficiently large and clear to avoid eyestrain and the volume is tastefully bound.

The Editors' intention to produce a reference book for general practitioners has certainly been achieved in this volume and it can be recommended with confidence. It would be a good investment.

F.J.F.

## ORTHOPAEDIC NURSING

*Calderwood's Orthopaedic Nursing.* Revised by Carrol B. Larson, M.D., F.A.C.S. and Marjorie Gould, R.N., B.S., M.S. (Pp. 687, with 284 illustrations. Third edition, £2. 9s. 0d.). St. Louis: The C. V. Mosby Company, 1953.

*Contents:* *Unit I. Introduction for the Teacher and the Student.* 1. Principles of Good Nursing Care Applied to the Orthopaedic Patient. 2. Rehabilitation. *Unit II. General Features of Orthopaedic Nursing.* 3. Nursing Care of Cast Patients. 4. Nursing Care of the Orthopaedic Surgical Patient. 5. Orthopaedic Linen and Restraints. *Unit III. Congenital Deformities.* 6. Congenital Deformities. 7. Nursing Care of Patients with Congenital Deformities. *Unit IV. Developmental Diseases of Bone.* 8. Developmental Diseases of Bone. *Unit V. Infections of Bones and Joints.* 9. Osteomyelitis: Acute and Pyogenic Arthritis. 10. Nursing Care of Patients with Osteomyelitis and Septic Conditions of the Joints. 11. Tuberculosis of the Bone and Joints. 12. Nursing Care of Patients with Skeletal Tuberculosis. *Unit VI. Metabolic Disorders of Bone.* 13. Metabolic Disorders of Bone. *Unit VII. Arthritis.* 14. Arthritis. 15. Nursing Care of the Patient with Arthritis. *Unit VIII. Poliomyelitis.* 16. Poliomyelitis. 17. Nursing Care of Patients with Poliomyelitis. *Unit IX. Cerebral Palsy.* 18. Cerebral Palsy. 19. Nursing Care of Patients with Cerebral Palsy. *Unit X. Common Painful Affections in Adults.* 20. Low Back Pain. 21. Nursing Care of Patients with Conditions of the Low Back. 22. Bursitis. 23. Disabilities of the Feet. *Unit XI. Special Operative Procedures.* 24. Special Operative Procedures. 25. Nursing Care Following Amputation. *Unit XII. Fractures and Dislocations, Sprains, and Other Joint Injuries.* 26. Introduction. 27. Fractures of the Skull, Face, and Jaw: Fractures of the Clavicle (Collar Bone): Fractures and Dislocations of the Shoulder. 28. Fractures of the Arm, Forearm and Wrist. 29. Fractures in the Hand. 30. Fractures and Dislocations of the Spine, Hip and Pelvis. 31. Fractures of the Femur. 32. Fractures about the Knee, Ankle and Foot. 33. Compound Fractures and First Aid. 34. Nursing Care of the Fracture Patient. 35. Nursing Care of the Fracture Patient, Cont. *Unit XIII. Traction.* 36. Nursing Care of the Patient in Traction. *Unit XIV. Bone Tumors.* 37. Bone Tumors. *Unit XV. Neuromuscular Affections.* 38. Progressive Muscular Dystrophy. 39. Birth Palsy (Erb's Paralysis). 40. Charcot Joints and Other Neuromuscular Affections (Neuropathies).

This standard book on orthopaedic nursing has now reached its 3rd edition. All the modern treatments have been brought up-to-date, including the orthopaedic nursing of traumatic cases of which so many occur these days.

The section dealing with rehabilitation is exceedingly useful and shows how large a part good nursing can play in promoting complete recovery.

Infantile paralysis has been well dealt with, and the part dealing with iron lungs is particularly interesting.

Here and there the book tends to extend a little further than nursing and becomes a book on orthopaedic surgery.

This work is highly recommended to orthopaedic nurses.

L. B.

## NYWERHEIDSGESONDHEID EN -VEILIGHEID

*Gesondheid en Veiligheid in die Nywerheid.* Opgestel deur Gerald Machanik. Uitgegee deur die Kantoor van die Ongevalle-kommissaris.

*Inhoud:* 1. Die Ongevalle en Fabriekswette. 2. Ventilasie, Beligting en Visie. 3. Goeie Huishouding, Persoonlike Geriewe en Veiligheidsreëls. 4. Rug-verrekkings: Voedsel. 5. Ongevalle, Moegheid en Verveling, Gesonde Lewenswyse.

'n Kort en nuttige uiteensetting van die ongevalle en fabriekswette in soverre hierdie Wette die gesondheid, geluk en welvaart van die fabriekswerker raak.

Dit is verblydend om te sien dat die klem op voorkoming van ongelukke en ongesonde liggaams—sowel as geestes-toestande gelê word. Dis egter te betwyfel of die gewone vakleerling vir wie hierdie verhandeling bedoel is, sonder meer, die volle waarde sal trek uit al die nuttige wenke oor kos, lewensgewoontes, ventilasie, beligting, gesindheid teenoor werk, ens. Inspirerende praatjies oor hierdie onderwerpe behoort die lees van hierdie boekie vooraf te gaan.

Dis jammer dat die Afrikaanse teks 'n byna woordelike vertaling uit die Engels is—hoewel heeltemal verstaanbaar is die gebrek aan aanvoeling vir goeie Afrikaans hinderlik en soms selfs irriterend.

C.J.G.

## PHYSIOLOGY OF NEUROLOGY AND PSYCHIATRY

*Physiological Foundations of Neurology and Psychiatry.* By Ernst Gellhorn, M.D., Ph.D. (Pp. 556 + xiii with 107 figures. \$8.50) Minneapolis: University of Minnesota Press, 1953.

*Contents:* Introduction. *Part I. Intrinsic and Extrinsic Factors Regulating Neuronal Activity.* 1. The Unit Analysis of Nervous Activity. 2. The Internal Environment and Central Nervous Activity. *Part II. Contributions to the Physiology and Pathology of Movements.* 3. The Motor Cortex and the Physiology of Movements. 4. Voluntary Movements, Motor Cortex and Reflex Activity. 5. The Restitution of Movements after Central Lesions. 6. Electromyography. 7. Studies on Experimental Convulsions. *Part III. The Physiological Basis of*



Consciousness. 8. An Approach to the Problem. 9. The Physiology of Consciousness. 10. The Pathology of Consciousness. Part IV. Some Aspects of Autonomic Physiology. 11. Neurohumors and Neuropharmacology of the Autonomic Nervous System. 12. The Eye as an Indicator of Autonomic Activity. Part V. Integrations. 13. Principles of Neuro-Endocrine Action. 14. The Physiological Basis of Emotion. 15. Factors Involved in Conditioning. 16. Homeostasis. 17. The Constancy of the External Environment. Part VI. Applications. 18. Schizophrenia. The Autonomic Nervous System and Shock Therapy. 19. The Physiological Foundation of Carbon Dioxide Therapy. 20. Physiological Principles for the Therapy of Psychoneuroses and Functional Psychoses. Bibliographical Index of Authors. Subject Index.

Progress in Neurology and Psychiatry, as in any other branch of medicine, occurs in direct relation to the scientific curiosity of workers in the clinical field in co-operation with their colleagues in the laboratories of many related disciplines. Observation and description, however careful and meticulous, and however adequately and even beautifully translated to paper, are not enough. The questions 'How?' 'Why?' 'Where?' and many others must be asked and answers searched for if a subject is not to remain static and relatively sterile. A fairly recent episode in the story of neurology is a pretty example of this: The discovery that in hepato-lenticular degeneration (Wilson's disease) there is a disturbance in metabolism of copper, and of amino-acid, has shifted emphasis from clinico-pathological concepts to a disorder of metabolism. Considerable therapeutic benefits have ensued

and a new vista is revealed in the sphere of 'degenerative' disorders of the nervous system. Unless Psychiatry is brought back into the field of Medicine and tackled by the same energetic and enquiring methods as are applied in other scientific fields it will make no worth-while progress.

The author of this book has himself conducted many experiments connected with the physiological functions of the nervous system in health and disease; he always brings to bear on his enquiries a balanced attitude that is equally concerned with the evidence of clinical phenomena and of laboratory experimentation.

It is a happy occasion to welcome this excellent book of his, which covers a wide field and 'proves the fruitfulness of the physiological method for the study of pathological phenomena and the rewards for physiology itself of this type of research'. It is unnecessary to deal in detail with the subject matter of the book; the chapter headings are self-explanatory. The chapters on the physiology of the motor cortex, the pharmacology of the nervous system, and the physiological basis of emotion are particularly outstanding.

The book must be read by every neurologist, psychiatrist, and physiologist; and the physician whose field is more extensive will find it most rewarding.

S.B.

## CORRESPONDENCE : BRIEWERUBRIEK

### THE SPECIALIST REGISTER

*To the Editor:* The request of the Secretary of the Special Committee dealing with the above-mentioned problem, that Branch discussions should be limited to those of making additions or subtractions to the 'for' and 'against' arguments is somewhat unfortunate in that it omits to ask for the reasons for any decisions adopted. Living in widely separated areas as we are, without opportunity for personal contact or interchange of opinion an overall assembly of individual views would be most helpful and perhaps the *Journal* could open its correspondence columns for this particular purpose. The Committee has produced a memorandum which reflects a tremendous amount of work and it is to be congratulated on its achievement to date, but it would be a pity if its endeavours were spoilt by the fact that it has not been possible for it to take its evidence in every important area in the Union.

In some of its conclusions it runs the risk of faulty planning based on inaccurate assumptions. For instance in considering the setting up of a consultant register it instances the patient-specialist relationship as operating in the Medical Aid Societies. It refers to this as the perfect consultant set-up, as it is, and states that the Societies find it gives them adequate service, as it does not. Speaking from the point of view of the Physicians' Group in Durban I say that this conclusion is completely unrelated to the facts. General practitioners do not make use of this service except in a very limited manner. To off-set this, most of these patients come directly to the specialist and the Societies give this their blessing by paying the specialists' charges promptly and without question.

The memorandum suggests that should a consultant register be established the consultant would receive a higher fee for his services than the specialist does at present. This would mean that for service which in my opinion would be no better than as at present the patient would be mulcted of a higher fee. Obviously this service is designed to be a rich man's service.

In the light of this reasoning the question 'Are you in favour of a consultant register?' becomes easier to answer and at the same time it suggests a further query, to wit, 'Are you in favour of taking the opinion of the patient in devising these services?' Free choice of doctor by the patient is one of our most cherished obligations and it was interesting to read that the Minister has set his face against any interference with the right of the patient to go direct to the specialist. I wonder if he knows that the right of the specialist to go direct to the patient in his own home has become anathema.

The wishes of the patient in this self-imposed apartheid for specialists have never been consulted. Is this just or proper, bearing in mind that the patients, who in the past enjoyed these services at general-practitioner level and costs, may now only obtain them at a cost which to the majority of them is prohibitive? It would seem that while the 'cost of living' is to be raised the

'cost of dying' may be made much cheaper. It is time that some finality were reached in this specialist-patient G.P. relationship; and with the proviso that the Specialist should stick to his speciality and charge his own tariff of fees the next question becomes, 'Are you in favour of domiciliary attendance of patients by all members of the profession wishing to give expression to the obligations of the Hippocratic oath?'

And now let us review the last of the problems deriving from the setting up of the specialist register. Not only has it engendered antagonisms between specialist and G.P. and between both these and patients but it has inevitably tended to lower the standard of G.P. training by contributing to the steady removal of these practitioners from hospital staffs. That is referred to in the memorandum as a probability and is in effect a fact. Opportunities for the G.P. to improve and maintain a high standard of efficiency are becoming progressively less and from the point of view of hospital training will shortly reach vanishing point unless something drastic is done about it. This prompts our last question, 'Are you in favour of a more generous integration of G.P.s into hospital services?'

As mentioned previously, I feel that the Committee has done a great job of work but has fallen short of perfection by its failure to take evidence and to hear diverse views and opinions in various parts of the Union. Is it too late before issuing the final questionnaire to have this done in part, if not in whole?

This becomes all the more desirable if we are prepared to admit that it is not the specialist register which is our main trouble, nor is it the question whether it should be supplemented by or replaced by a consultant register. The whole basis of medical supply and demand and of relationships between doctor and doctor and doctor and patient have been distorted out of all recognition. A referendum of limited scope will not suffice to restore harmony unless it is based on accurate knowledge of the why and the wherefore of the present atmosphere of distrust, suspicion and veiled enmity.

The roots of the trouble go much deeper than the agitation for and against registration of specialists and/or consultants. The sooner we realize this and grasp the problem with resolution and with a determination to eradicate it permanently the better for all concerned, but first of all we must delve and dig to disclose it in all of its ramifications. We have the right type of Committee for this purpose, but many of us do not believe that it can achieve its object sitting in Johannesburg, but that it should take evidence in each individual centre in turn. Is it impossible or too late to do this?

J. Drummond, M.D., F.R.C.P., Ed.

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2 April 1954

[The correspondence columns are open—Editor]

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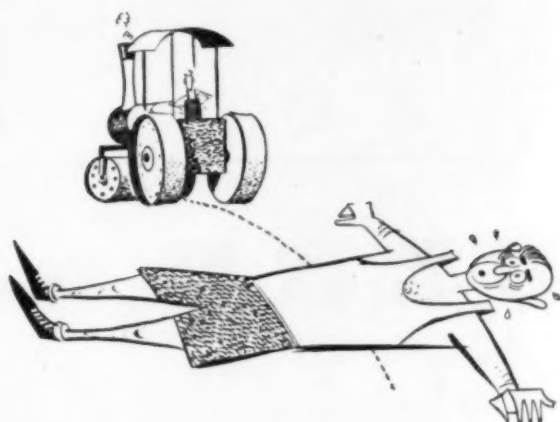
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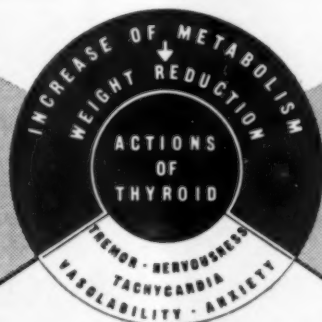
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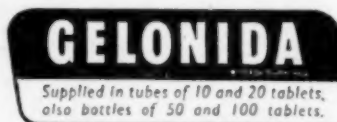
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(LM9) Natal South Coast. Locum required for July. £3 3s. per day, all found. Must have own car. General mixed country practice.

## ASSISTANTS REQUIRED

(AM1) Assistant required in general mixed practice near Durban, as soon as possible, must be experienced and fully bilingual. House available. Possibility of partnership. Full details on request.

(AM2) Assistant required for trial period. If suitable, partnership will be offered. General practice in select area approximately 20 miles from Durban.

## ASSISTANTSHIP REQUIRED

(AR1) Young married doctor, qualified 8 years, experience in obstetrics and gynaecology and surgery, seeks assistantship with view to partnership in general practice.

AGENCY DEPARTMENT : AGENTSAP-AFDELING  
CAPE TOWN : KAAPSTAD

P.O. Box 643, Telephone 2-6177 : Posbus 643, Telefoon 2-6177

## PRACTICES FOR SALE : PRAKTYKE TE KOOP

(1280) Ciskei rural practice. Gross receipts £3,151. Premium required £1,500 including instruments, large stock of drugs, fittings and furniture. Terms available. Knowledge of Native language not essential.

(1399) Transkei. Unopposed prescribing practice. Cash receipts 1950/51/52—£3,887, £4,814, £5,064. Two appointments. Practically no night work. Premium required £2,200. Large house for sale at £2,300. Jeep also offered for sale. Terms possible.

(1436) Goedgevestigde Karoo-praktik. Ontvangste ongeveer £3,000 p.j. D.S. en M.O.H. aanstellings. Koopprijs £1,500 wat voorraade insluit. Gerieflike woning met spreekkamers beskikbaar teen besonder billike huur.

(1276) S.W.A. hospital town. Well-established prescribing practice. Cash income—£3,300 p.a. THIS IS AN EXCELLENT OPPORTUNITY to acquire a very good practice with full scope for surgery at an exceptionally low premium as the owner wishes to sell as soon as possible in order to specialize. Premium for goodwill, instruments and excellent surgery furniture £1,600. Terms possible.

(1652) Small coastal town in Eastern Cape. D.S. and M.O.H. appointments. Prescribing and dispensing practice. Annual income about £3,000. Considerable scope for expansion. Premium required £1,500 including drugs, instruments and office furniture.

(1654) Eastern Province. Exceptionally pleasant HOSPITAL TOWN. Excellent opportunity to do surgery. Suitable for English- or Afrikaans-speaking doctor. Premium required £1,500. Terms could be arranged.

## ASSISTENTE/PLAASVERVANGERS VERLANG ASSISTANTS/LOCUMS REQUIRED

(1626) Wes-Kaapland. Plaasvervanger vanaf 1 Augustus vir 6 weke. Salaries £3 3s. per dag plus reisonkoste en losies (kwoteer ook (1631)).

(1628) Transkei. Assistant from mid-May for 6-12 months. £80 p.m. plus car allowance. Car not essential. 90% Native. Hospital facilities.

(1584) Noordkaapland-hospitaaldorp. Assistent met definitiewe oog op vennootskap vanaf 1 Maart. Salaries £100 p.m. plus petrol-toelaag. Eie kar noodsaaklik. Dit is 'n vennootskapspraktik met D.G.-aanstelling. Spoorweg en Myne. Fasiliteite vir sny- en kraamwerk.

(1612) Eastern Province. Locum as soon as possible for one month. Salary £75 p.m. all found. Partnership practice. Possibility of assistantship.

## JOHANNESBURG

Medical House, 5 Esselen Street. Telephone 44-9134-5, 44-0817  
Mediese Huis, Esselenstraat 5. Telefoon 44-9134-5, 44-0817  
(Pr/S101) Oos-Transvaal. 'n Jong praktik wat vinnig groei, in 'n vooruitstrewende omgewing. Jaarlikse inkomste van ongeveer £2,000. Premie van £500 kan maandeliks afbetaal word.

(Pr/S104) Johannesburg. Well-established prescribing practice, in excellent position. Monthly cash receipts average £250. Three months introduction will be given. Premium required is £1,900 and includes surgery equipment, furniture and instruments and a diathermy machine. No night calls. An Afrikaans-speaking doctor will do well in this practice.

(Pr/S106) Randse hospitaaldorp. Ou-gevestigde praktik met twee oordraagbare aanstellings. Jaarlikse inkomste nooit minder dan £2,400. Premie is £1,500 en kan afbetaal word. Geen chirurgie word gedoen nie, maar bied goeie geleentheid aan iemand wat daarin belangstel.

(Pr/S107) O.V.S. Goedgevestigde, winsgewende praktik. Chirurgie word onderneem. Gemiddelde jaarlikse inkomste is £3,800. Premie is £1,250 en sluit medisyne en 'n goeie voorraad instrumente in en terme kan gereël word. Aangename dorp met welvarende boeregemeenskap.

(Pr/S108) Transvaal. Goedgevestigde, winsgewende praktik met aanstellings. Die volle praktik kan oorgeneem word of 'n vennootskap (volle helfte aandeel) of 'n assistentskap met oog op vennootskap. Die assistent sal ver wag word om dan na 3 maande 'n vennootskap te koop. (Die assistent se salaris sal £110 p.m. wees, plus vry petrol en olie en £15 tot £20 p.m. kartoelae.) Die gemiddelde bruto-inkomste van die praktik is £7,000/£8,000 per jaar en die netto is ongeveer £5,000 p.j. Premie verlang is £2,500 vir 'n vennootskap en £4,000 vir die volle praktik. Baie billike terme sal gereël word.

(Pr/S109) Transvaal hospital town. Well-established practice with two transferable appointments. Annual income well over £3,500. It is a mixed general practice, and the native side could be considerably expanded. Surgery is undertaken. Practice most suitable for two doctors. The owner will consider an outright sale at a premium of £2,250 and a deposit of £500 or a PARTNERSHIP at a premium of £1,000, on terms. Buyer must have an excellent knowledge of Afrikaans. Will suit doctor interested in surgery and/or gynaecology.

(Pr/S111) Oos-Transvaal. Ongeopponeerde praktyk met D.G.-aanstelling. Jaarlikse inkomste £4,800. Groot huis, met spreekkamers, word te koop aangebied. Praktyk geskik vir twee geneesheren.

(Pr/S114) Johannesburg. Old-established practice with a transferable appointment. Practice covers Northern suburbs. Low rental and expenses. Knowledge of Afrikaans not essential.

(Pr/S115) Johannesburg. 'n HELFTE AANDEEL word aangebied in 'n ougevestigde vennootskapspraktyk. Jaarlikse inkomste £3,000 netto per vennoot. Hierdie praktyk word goed bestuur en is uiters geskik vir 'n Afrikaanse geneesheer wat hom in die stad wil vestig.

(Pr/S116) Reef hospital town. HALF SHARE in old-established partnership practice. Annual income per partner £2,600/£2,800 net. Will suit doctor interested in surgery.

(Pr/S117) Southern Rhodesian hospital town. Excellent practice with a transferable appointment worth £500 p.a. 1953 Income over £3,700 (excluding income from appointment). Premium of £1,200 includes furniture and instruments. Terms could be arranged.

(Pr/S118) O.V.S. Hospitaaldorp. 'n Uitstekende, goedgevestigde, winsgewende praktyk teen 'n baie redelike prys. Aangesien die eienaar gaan spesialiseer en baie haastig is om te verkoop, is die premie vir hierdie praktyk wat al 14 jaar bestaan, uiters redelik. Volle besonderhede op aanvraag.

## Provincial Administration of the Cape of Good Hope

### HOSPITALS DEPARTMENT HOSPITAL BOARD SERVICE: VACANCY

1. Applications are invited from registered medical practitioners for appointment to the following vacant post:

Institution	Post	Emoluments	Closing Date	Applications to be addressed to:
Woodstock Hospital,	Medical Practitioner,	£1,000x50-1,200 p.a.	12.5.54	The Director of Hospital Services, P.O. Box 2060, Cape Town.
Woodstock, Rondebosch Hospital,	Grade C, (Medical Superintendent)			
Rosebank, Mowbray Maternity Hospital,				
Mowbray Peninsula Maternity Hospital,				
Cape Town, Steyning Maternity Clinic,				
Claremont				

2. Conditions of service are prescribed in terms of Hospital Board Service Ordinance No. 19 of 1941, as amended, and the regulations framed thereunder.

3. In addition to the scale of salary indicated, a cost of living allowance at rates prescribed from time to time by the Administrator is payable to whole-time officials and employees.

4. The successful candidate will be required to occupy, free of charge, an unfurnished house or quarters provided at the institution or alternatively, if a house or quarters are not available, to occupy a house approved by the Department in respect of which the Department will contribute an amount of not exceeding £180 per annum towards the rental.

5. The successful candidate, if not already in the Hospital Board Service, will be required to submit satisfactory birth and health certificates.

6. Application must be made on the prescribed form (Staff 23), which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Medical Superintendent of any Provincial Hospital or Secretary of any School Board in the Cape Province.

7. Candidates must state the earliest date on which they can assume duty.

(M127088)

## Vacancies

Applications are invited for the undermentioned posts:

Post	Institution	Salary Scale
A. Vice-Principal Grade B (Female).	Elizabeth Conradie School, Kimberley.	£870 x 40 1,110—1,160.

Minimum qualifications: A teachers' certificate or equivalent qualification.

Any special qualifications for the care of physically handicapped girls should be stated.

B. Medical Officer (Male or Female).	Vocational High School for Boys, Kimberley.	£1,020 x 60—1,380.
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Minimum qualifications: Registration with S.A. Medical and Dental Council as medical practitioner.

Cost of Living Allowance: Married, £234 p.a. Single, Nil.

Application forms and further particulars are obtainable from the Secretary, Department of Education, Arts and Science, Van der Stel Buildings, Pretoria. Applications must reach him not later than 8 May 1954.

(45221)

## Provinsiale Administrasie van die Kaap die Goeie Hoop

### HOSPITAALDEPARTEMENT HOSPITAALRAADSDIENS: VAKATURE

1. Aansoeke word ingewag van geregistreerde geneesheren vir aanstelling tot die volgende vakante pos:

Inrigting	Pos	Emolumente	Sluitingsdatum	Aansoeke moet gerig word aan:
Woodstock-hospitaal, Woodstock, Rondebosch-hospitaal, Rosebank, Mowbray Kraam-hospitaal, Mowbray, Skiereilandse Kraam-hospitaal, Kaapstad, Steyning Kraam-kliniek, Claremont	Geneesheer, Graad C. (Mediese Superintendent)	£1,000x50-1,200 p.j.	12.5.54	Die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad.

2. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaaltraadsdiens no. 19 van 1941, soos gewysig, en die regulasies wat daarkragtig opgestel is.

3. Benewens die salarisskaal soos aangedui is 'n lewenskoste-toelae betaalbaar aan voltydse beamptes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word.

4. Van die geslaagde kandidaat sal dit vereis word om 'n onge-meubileerde huis of kwartiere wat by die hospitaal verskaf word gratis te bewoon, of as 'n huis of kwartiere nie beskikbaar is nie, 'n huis te bewoon wat deur die Departement goedgekeur is ten opsigte waarvan die Departement 'n bedrag van hoogstens £180 per jaar tot die huur sal bydra.

5. Die geslaagde kandidaat, indien nie reeds in die Hospitaaltraadsdiens nie, moet bevredigende geboorte- en gesondheids-sertifikate indien.

6. Aansoek moet gedoen word op die voorgeskrywe vorm (Staf 23), wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige Provinsiale Hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinsie.

7. Applikante moet die vroegste datum meld waarop hulle diens kan aanvaar.

(M127088)



## Transvaal Provincial Administration

### VACANCIES : TRANSCAAL PUBLIC HOSPITALS

Applications are invited from suitably qualified candidates for the undermentioned posts at Public Hospitals in the Transvaal.

Applications should be addressed to the Medical Superintendents of the undermentioned Hospitals concerned and should contain full particulars as to the age, professional and academic and language qualifications, experience and conjugal status of the applicant and should further indicate the earliest date upon which duties can be assumed. Copies, only, of recent testimonials to be attached.

Cost of Living Allowance payable at present to full-time employees:

### COST OF LIVING ALLOWANCE

Salary	Married	Single
Over £350 p.a.	£320 per annum	£100 per annum

Full-time employees receive in addition to their salaries and cost of living allowance, the following privileges:

Leave and rail concession.

Successful candidates will be required to submit satisfactory certificates as also to submit to a medical examination at the hospital concerned.

Application forms are obtainable from any Transvaal Provincial Hospital or the Provincial Secretary, Hospital Services Branch, P.O. Box 2060, Pretoria.

The closing date of applications for undermentioned posts will be 12 May.

Post	Hospital	Emoluments	Remarks
Part-time General Practitioner Surgeon.	Potchefstroom .. ..	£425 per annum, 2½ sessions per week.	Registered medical practitioner. Higher degree in surgery a recommendation.
Senior Anaesthetist .. ..	Pretoria .. ..	£2,000 per annum .. ..	Registered medical practitioner. Higher degree in anaesthetics in essential.
Clinical Assistant (Department of Anaesthetics).	Pretoria .. ..	£620—780—820—860 .. ..	Registered medical practitioner. Must be qualified for at least two years. Must assume duty 1.10.54.
Clinical Assistant (Department of Anaesthetics).	Pretoria .. ..	£620—780—820—860 .. ..	Registered medical practitioner. Must be qualified for at least two years. Must assume duty 1.3.55.
Senior Resident Medical Officer	Pietersburg .. ..	£480 per annum. Plus free Board and quarters or an allowance of £120 per annum in lieu thereof.	Registered medical practitioner.
	Klerksdorp .. ..	Do.	Do.
	Paul Kruger Memorial, P.O. Rustenburg.	Do.	Do.
	Standerton .. ..	Do.	Do.

(45254)

### Tristan da Cunha — Medical Officer

Doctor required for general medical duties on South Atlantic Island of Tristan da Cunha.

Appointment would be on agreement for two years. Salary, £1,200 a year. No income-tax. Free quarters provided equipped with heavy furniture, for which a small rental may be charged. Free passages provided for officer, wife and up to three children to and from the Island. Generous home leave granted after tour. Private practice is not permitted. Special importance will be attached to suitability of personal qualities for service in this small, remote but distinctive community.

Application forms can be obtained from the Second Secretary, United Kingdom High Commissioner's Office, 91 Parliament Street, Cape Town.

### Factory Doctor at Umkomaas

The South African Industrial Cellulose Corporation (Pty.), Limited, which is in the process of establishing a factory about two miles from Umkomaas, South Coast, Natal, for the purpose of undertaking the manufacture of rayon pulp intends to introduce a medical benefit scheme for its European employees and their families (many of whom will be Italian immigrants) and for its non-European employees. The Corporation will employ in the region of 250 Europeans and 400 natives. An adequately equipped surgery will be provided at the factory and a fully qualified nurse who speaks both English and Italian fluently will be in attendance.

The corporation now invites applications for the part-time post of factory doctor who will be required to undertake medical duties at the factory surgery for a given period each day and to attend to such emergency cases as may arise. His remuneration will be on the basis approved by the Medical Association. Applications in writing should be addressed to the Corporation, P.O. Box 2642, Durban.

### BRIDGMAN MEMORIAL HOSP., JOHANNESBURG—

#### HOUSE SURGEONS IN OBSTETRICS

Applications are invited from Medical Practitioners for three posts of House Surgeon in Obstetrics at the above Non-European Maternity Hospital for the period 1 August 1954 to 31 January 1955 inclusive. Successful applicants may be required to lecture to Pupil Midwives.

Salary £480 per annum plus married or single cost-of-living-allowance, board, lodging and laundry.

Closing date for applications: 17 May 1954.

Applications with a complete list of previous experience should be sent to the Superintendent, Bridgman Memorial Hospital, High Street, Mayfair, Johannesburg.

#### PARTNERSHIP OFFERED

From early 1955, to experienced General Practitioner capable of doing major surgery, in extensive practice in pleasant Hospital town. Write for full particulars to 'A.V.A.', P.O. Box 643, Cape Town.

#### PRACTICE OR PARTNERSHIP REQUIRED

English M.R.C.S., C.R.C.P., D.T.M. & H. requires practice or partnership in Cape, Johannesburg or Durban. Age 30, married, good hospital and general experience. Reply: Knight, P.O. Box 131, Mwanza, Tanganyika.



## The Divisional Council of the Cape

### VACANCY FOR JUNIOR MEDICAL OFFICER AT THE DR. A. J. STALS MEMORIAL SANATORIUM

Applications are invited from Registered Medical Practitioners (European male or female) for the undermentioned vacancy at the Dr. A. J. Stals Memorial Sanatorium (treatment of non-European females and children Tuberculosis patients) Westlake, Retreat:

#### JUNIOR MEDICAL OFFICER

At a salary on the commencing notch on the scale £624 x 36—£840 per annum plus cost of living allowance plus an allowance of £192 per annum in lieu of board and lodging which is not available at the Sanatorium.

Applications must contain full details of qualifications and previous experience, marital state and whether bilingual, and should indicate the earliest date on which duty could be commenced.

The successful applicant will be required to serve a probationary period of six months and, on confirmation of appointment, to become a member of the Council's Pension Scheme and of the South African Association of Municipal Employees. Medical fitness is therefore a condition of appointment.

Any further information required may be obtained upon enquiry direct to the Medical Officer of Health of this Council.

Applications must be addressed in writing to the undersigned to reach the Council's offices not later than Tuesday, 18 May 1954.

Canvassing of Councillors or officials will prove a disqualification.

C. V. Emms  
Acting Secretary

6 Dorp Street  
Cape Town  
9 April 1954

(1025)

## Local Health Commission

### VACANCIES FOR ASSISTANT MEDICAL OFFICERS OF HEALTH (2)

#### Amended Notice

Applications are invited from registered Medical Practitioners possessing a recognized Diploma in Public Health or State Medicine to fill the above permanent pensionable positions on the salary grade £1000 x 50—£1150 per annum, plus cost-of-living allowance, which is at present:

Married officials: £352 per annum

Further particulars are obtainable from the undersigned on application.

The appointments and commencing salary are subject to the prior approval of the Minister for Health.

Applications in sealed envelopes addressed to the Secretary, Local Health Commission, and marked 'Application for Assistant Medical Officer of Health', will be received until NOON on MONDAY, 10 MAY 1954.

D. R. Donaldson  
Secretary

Local Health Commission Offices  
195 Longmarket Street  
Pietermaritzburg  
2 April 1954

(4175)

## O.F.S. Provincial Administration

### VOORTREKKER HOSPITAL KROONSTAD

#### VACANCIES FOR INTERNS

Applications are invited to fill existing vacancies for the posts of Interns and House Surgeons.

Salary scale Interns: £240 p.a. plus c.o.l. allowance.

Salary scale House Surgeons: £300 p.a. plus c.o.l. and free board and lodging.

F. A. van Coller  
Medical Superintendent

Kroonstad  
30/3/54

(A43299)

## University of Natal

### VACANCIES

#### MEDICAL SCHOOL, DURBAN

Applications are invited from suitably qualified persons for appointment to the following posts on the staff of the Medical School at Durban:

- Professor of Medicine.
- Professor of Surgery.
- Professor of Gynaecology and Obstetrics.

The salary attached to each of the posts will be £2,500 per annum, plus a temporary cost of living allowance of £320 per annum payable only to married men.

The appointment will be made jointly by the University and the Natal Provincial Administration, and membership of the University Institutions' Provident Fund will be compulsory, contributions being at the rate of 7 per cent of basic salary.

Those appointed will have charge of beds in the teaching hospital (King Edward VIII Hospital), and they will have to pioneer the establishment of the Departments of Medicine, of Surgery and of Gynaecology and Obstetrics. Although the teaching of students, who are all non-Europeans, will not commence until 2 February 1955, it is most desirable that the persons appointed should assume duty not later than 1 November 1954.

A successful candidate appointed from within the Union of South Africa or from territories adjoining the Union (including Northern Rhodesia) shall be provided with a first class railway fare for himself and, in the case of a married officer, for his wife from his home to Durban. Removal expenses not exceeding £50 may be granted.

A successful candidate from any other place than those mentioned in the preceding paragraph shall be allowed £200 if married and accompanied by his family, or £100 if single, for his expenses; provided that in the event of resignation from office before the expiration of three years for reasons other than those of health, he shall refund, at the discretion of the Council, such portion of the monetary allowance for his passage as is proportionate to the unexpired portion of the said period of three years.

Applications (on the prescribed form) must be lodged with the Registrar, University of Natal, King George V Avenue, Durban, on or before 31 May 1954. Further particulars may be obtained from the Registrar.

#### ASSISTANTSHIP REQUIRED

Assistantship with possible view to partnership required by young doctor, preferably in the Cape. Experience in hospital and general practice. Reply to 'A.V.B.', P.O. Box 643, Cape Town.

#### PRACTICE FOR SALE

For sale in Southern Rhodesia a small specialist practice, capable of expansion in any direction. Equipped surgery available from 1 November. Accommodation also available. Incumbent retiring. Apply 'A.U.Z.', P.O. Box 643, Cape Town.

#### KIMBERLEY HOSPITAL, KIMBERLEY

##### VACANCIES

Six posts interns (contract period 1 June 1954 to 31 December 1954). 3970

## O.V.S. Provinsiale Administrasie

### VOORTREKKER-HOSPITAAL KROONSTAD

#### VAKATURES—INTERNS

Aansoek word ingewag vir genoemde vakatures vir die pos Intern en Huisdokters.

Salarisskaal Intern: £240 p.j. plus lewenskoste.

Salarisskaal Huisdokters: £300 p.j. plus lewenskoste, plus vry inwoning.

F. A. van Coller  
Geneesheer-Direkteur

Kroonstad  
30/3/54

(A43299)

# *Taking the brake off*



## *convalescence*

Convalescence is as much a state of mind as of body. Getting well requires the patient's

enthusiasm, and nothing evokes this enthusiasm more readily than a sense of improvement.

The function of a good tonic is to impart this sense by toning up slack muscle and by

stimulating appetite so that the patient quickly builds up his lost strength.

'Eskay's Neuro Phosphates' and 'Eskay's  
Theranates' are two outstanding tonics,  
pharmaceutically elegant and palatable.

'Eskay's Theranates' combines the proven  
formula of 'Neuro Phosphates' with Vitamin B<sub>1</sub>  
(1,000 International Units per fluid ounce).

### **'Eskay's NEURO PHOSPHATES'**

Each adult dose (2 teaspoonfuls) contains, in acid state:

Strychnine glycerophosphate	—	1/64th grain (1 m.g.)
Sodium glycerophosphate	—	2 grains (13c m.g.)
Calcium glycerophosphate	—	2 grains (13c m.g.)

### **'Eskay's THERANATES'**

the formula of 'Neuro Phosphates' plus Vitamin B<sub>1</sub> (1,000 International Units  
per fluid ounce).

**M. & J. PHARMACEUTICALS (PTY.) LTD., DIESEL STREET, PORT ELIZABETH**

MTP535A

for Smith Kline & French International Co., owner of the trade marks 'Eskay's Neuro Phosphates' and 'Eskay's Theranates'

ORANGE - FLAVOURED

**SUR-BEX SYRUP***has taste appeal too!*

A modified orange flavour effectively masks the bitterness of the vitamins, makes SUR-BEX SYRUP pleasant to take. No need to disguise it, for here is a B vitamin liquid that tastes good right from the spoon.

Each 5-cc. Teaspoonful of  
**SUR-BEX** contains:

THIAMINE	
HYDROCHLORIDE . . .	6 mg.
RIBOFLAVIN . . . . .	6 mg.
NICOTINAMIDE . . . . .	30 mg.
PYRIDOXINE	
HYDROCHLORIDE . . .	1 mg.
VITAMIN B <sub>12</sub>	
(as vitamin B <sub>12</sub> concentrate)	2 mcg.
BREWERS	
YEAST EXTRACT . . .	0.2 Gm.

**SUR-BEX TABLETS**

GOOD PROVIDER of B complex factors SUR-BEX spares the patient the unpleasant taste and odor of liver fraction, brewer's yeast and crystalline vitamins. The triple-coating assures stability, provides a pleasing vanilla flavour and aroma, minimizes the possibility of regurgitation.

Each **SUR-BEX** Tablet contains:

THIAMINE MONONITRATE	6 mg.
(6 times MDR*)	
RIBOFLAVIN	6 mg.
(3 times MDR*)	
NICOTINAMIDE	30 mg.
(2 times RDA†)	
PYRIDOXINE HYDROCHLORIDE	1 mg.
VITAMIN B <sub>12</sub> (as vitamin B <sub>12</sub> concentrated	2 mcg.
PANTOTHENIC ACID . . . . .	10 mg.
(as calcium pantothenate)	
LIVER FRACTION 2, N.F. . . . .	0.3 Gm. (5 grs.)
BREWER'S YEAST, DRIED . . . . .	0.15 Gm. (2½ grs.)

\* MDR—Minimum Daily Requirement  
† RDA—Recommended Daily Dietary Allowance

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